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Concise report on world population monitoring, 2000: population, gender and development

Report of the Secretary-General

Summary

The present report has been prepared in accordance with the terms of reference of the Commission on Population and Development and its topic-oriented prioritized multi-year work programme, which was endorsed by the Economic and Social Council in its resolution 1995/55. The Commission, in its decisions 1998/1 and 1999/1, decided that the theme for the Commission at its thirty-third session in the year 2000 should be "Population, gender and development".

The report provides a summary of selected aspects of population, gender and development. It includes a historical review of population and gender issues in the global agenda and provides recent information on such topics as family formation, health and mortality, including human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), ageing, and internal and international migration. The preliminary, unedited version of the full report is available as a working paper in document ESA/WP/159.

The report was prepared by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat with a contribution from the Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) (UNAIDS).

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Introduction: population and gender in the global agenda

1. Concern with population and gender matters formally entered the global agenda soon after the founding of the United Nations. During the last half-century, two fundamental developments have been discernible. First, emphasis on human rights issues in population policies and programmes has increased. Second, gender policies have expanded from a focus on the status of women to gender equality, equity and the empowerment of women.

2. United Nations activities relating to population and gender began in 1946 when the Economic and Social Council established the Commission on the Status of Women[1] and the Population Commission.[2] In 1948, the General Assembly adopted the Universal Declaration of Human Rights,[3] which asserts, *inter alia*, that no distinction may be made on the basis of sex in entitlement to the rights and freedoms that it sets forth. It also affirms everyone's rights to life, to marry and found a family, and to move within and to leave one's own country — fundamental events of population change.

3. The 1950s and early 1960s were a period of preliminary consensus-building in the areas of both population and gender. In 1967, the General Assembly adopted the Declaration on the Elimination of Discrimination against Women,[4] which called for measures to eliminate barriers to the equality of women. The following year, the Assembly adopted the Proclamation of Teheran,[5] formulated by the International Conference on Human Rights in that city. The 1968 Proclamation stated, for the first time in an international instrument, that parents had a basic human right to determine freely and responsibly the number and the spacing of their children.

4. Another major advance in the area of gender occurred in 1979 when the General Assembly adopted the Convention on the Elimination of All Forms of Discrimination against Women.[6] It amplified the 1967 Declaration by calling for the modification of social and cultural patterns of prejudice based on ideas of inequality between men and women. It affirmed the equal rights of women and men to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

5. The next pivotal step in the area of gender came with the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, held in Nairobi in 1985. The Conference adopted the Nairobi Forward-looking Strategies for the Advancement of Women,[7] which introduced some important new perspectives. It called for women's playing a central role in development.

6. The 1995 Fourth World Conference on Women in Beijing took significant further steps. The concept of gender was widely used in its Platform for Action,[8] which stressed that, in addition to achieving equality of status, women should fully and actively participate in decision-making in all areas of life. At the same time, changes in men's roles, status and behaviour were to be expected and a gender perspective should be integrated in all policies and programmes. There was a strong call for the elimination of all forms of violence against women and for the rights of the girl child. The Platform fully reaffirmed the formulations on reproductive rights, reproductive health and family planning set forth by the 1994 International Conference on Population and Development held in Cairo.

7. There was a related process of change in the treatment of population in the global agenda. Following the Teheran International Conference on Human Rights in 1968, a series of three international population conferences provided the main forum for global population policy formulation.

8. The first of the three, the 1974 World Population Conference in Bucharest, adopted the World Population Plan of Action.[9] A key point in its principles and objectives[10] was that population trends are significant because of their relationship to socio-economic development. The Teheran formulation of the right to family planning was reaffirmed and extended to all couples and individuals. The right of women to complete integration in the development process was affirmed, as was their full participation in the formulation and implementation of socio-economic and population policies. Recognizing the family as the basic unit of society, the Plan of Action took up gender issues in the section entitled "Reproduction, family formation and the status of women".[11] The Plan called for the extension of girls' and boys' education, in order for them to contribute more effectively to economic activity, and for recognition of women's economic contributions in households and farming.

9. In 1984, the International Conference on Population was convened in Mexico City. It made important innovations in the area of population and gender. Its recommendations referring to the role and the status of women[12] were separated from those dealing with reproduction and the family,[13] and were given a prominent position in the report. Governments were urged to integrate women fully into all phases of development and assure their freedom to participate in the labour force. Through education, training and employment, women were to have opportunities for personal fulfilment. Men should be more involved in all areas of family responsibility. In promoting knowledge and policy, Governments should make available population and related data by sex. The 1984 Conference set a quantitative goal for reduction in maternal mortality. On reproduction and family size, it reaffirmed the formulation of the World Population Plan of Action. It observed that the family had many forms including single-parent families. In dealing with migration, it called for assistance to migrant women as well as to women left behind unsupported in rural areas. It also called attention to the growing numbers of refugee women.

10. The Programme of Action of the International Conference on Population and Development,[14] held in Cairo in 1994, further broadened and deepened the discussion of the population and gender relationships. The Programme of Action was built on concern for human rights. It described the human rights of women and the girl child as an inalienable, integral and indivisible part of universal human rights. It included a separate chapter (IV) entitled "Gender equality, equity and empowerment of women", where it introduced new topics and gave sharpness and specificity to previous recommendations. It called for the elimination of violence against women, for measures to enable women to combine maternal roles with participation in the workforce, and for women's empowerment in commercial transactions and equality in all terms of employment. Rape as an instrument of war was condemned. A section (B) devoted to the girl child called for the elimination of excess mortality of girls. Female genital mutilation should be eliminated. There was also a section (C) on male responsibilities and participation in family life and reproduction. In addition to the aforementioned separate chapter, gender issues were interwoven with many other issues throughout the Programme of Action. Nearly every chapter included recommendations related to gender issues or to women and girls.

11. The Programme of Action gave particular attention to the persistence of poverty, especially among women. Revised and more detailed quantitative goals were set for maternal mortality reduction. Attention to the needs of women who were international migrants, and especially those who were refugees, was called for, as were sanctions against those who engaged in any form of international trafficking in women. A separate chapter (XI) was devoted to population, development and education. It stressed the elimination of gender disparities and the empowerment of women through education. Research using gender-disaggregated data and research on male involvement in family planning were urged.

12. The twenty-first special session of the General Assembly for the overall review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development took place in June-July 1999. It found that there had been progress in implementing the Programme of Action, but that in some areas progress had been limited. The special session adopted a set of key actions for the further implementation of the Programme of Action.[15] They include recommendations on the promotion and protection of women's human rights, the empowerment of women, a gender perspective in programmes and policies and advocacy for gender equality and equity.

13. As population and gender policies and programmes have developed, so has the realization that there remains much more to be done. The Programme of Action and the key future actions call for gender disaggregated analysis of social and demographic processes. The present report is designed to contribute to a better understanding of the issues, and to more effective measures for dealing with them. The following sections contain a summary of recent information on the major components of population change and their linkages to gender. Specifically, this report covers patterns and trends in family formation, including nuptiality, contraception and fertility; mortality, including major causes of death, human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS); population ageing; and internal and international migration. The policies and activities of Governments with respect to each component are also reviewed.

I. Family formation

14. An important development in fertility and family studies has been the gradual shift from a nearly exclusive focus on women to a more balanced perspective that includes both men and women. The Programme of Action of the International Conference on Population and Development provided an important impetus for moving not only from a family planning to a more comprehensive reproductive health approach, but also from a woman-only approach to an approach including men and women. A growing recognition that knowledge of both men's and women's attitudes and behaviour is essential for a full understanding of fertility and family dynamics, has led to efforts towards incorporating men in research analyses and policy programmes. In order to fill the existing data gap, an increasing number of large-scale demographic surveys are beginning to include men in their national samples.

15. The role and status of men and women within a society play a major role in shaping individuals' entry into sexual life. There is growing evidence that gender inequality may jeopardize women's sexual and reproductive health by constraining their control over when to start to be sexually active, by increasing their vulnerability to risky sexual behaviour and by reducing their ability to negotiate protective measures with their partners. The onset of sexual activity typically takes places during the period of adolescence, when individuals are particularly vulnerable and in many cases too ill informed to make responsible choices.

16. In recent decades, both the timing and context of sexual initiation have undergone changes. Some studies have reported a trend towards a younger age of entry into sexual activity in more developed regions, but evidence is less conclusive for less developed regions, because of wide variation across countries. The fall in the age at menarche, due to enhanced nutrition and health, combined with an increasing age at marriage, has widened the gap between sexual maturation and family formation, lengthening the duration of exposure to sexual activity prior to marriage. This trend has raised a new awareness of the risks faced by unmarried young people, since they often have limited access to information and health-care facilities, including family planning, and therefore are more vulnerable to

the potential hazards of unprotected sexual activity, such as unintended pregnancies and sexually transmitted diseases.

17. The initiation of sexual activity during adolescence is an experience common to both men and women, but the timing and context in which it takes place often differ for them, particularly in developing countries. Generally men become sexually active at a younger age than women. However, recent data reveal that differentials are moderate and that the pattern differs by region. Whereas in most Latin American countries men's age at sexual initiation is earlier than women's, the opposite is true in several African countries. Larger gender differentials are found with regard to the context in which sexual initiation takes place. Among men, most sexual activity during the teenage years is non-marital, while for a large proportion of women it takes place within marriage. Another important aspect of entry into sexual life encompasses to what extent effective means of protection against both pregnancy and sexually transmitted diseases are being used. Data from both developed and developing countries indicate that the level of protection at the time of sexual initiation is low.

18. Early marriage tends to be more prevalent in societies where women's identity and status are primarily defined in connection with their family and childbearing roles. As education expands and women's roles become more diversified, early marriage tends to become less frequent. The timing of marriage, in turn, can also influence women's position in society and in the family. Early marriage, for example, often entails the discontinuation of schooling and may subsequently affect a woman's level of autonomy and power within the family.

19. Existing data reveal a large worldwide variation in the patterns of marital timing. The female median age at marriage ranges from 14 years in Bangladesh and approximately 16 years in India, Nepal and Yemen to over 26 years in Japan and several European countries. A general trend towards marriage postponement has been documented for most regions of the world. In the more developed regions, part of the rise in age at marriage is linked to the increasing prevalence of cohabitation at younger ages. An increasing rate of marital disruption and a declining pace of remarriage following divorce are also increasing the amount of time adult women spend outside marriage.

20. While entering marriage during adolescence is a customary pattern for women in many developing countries, adolescent marriage is rare among men in most societies, mainly because prevailing social norms emphasize men's ability to support a family economically as a precondition for marriage. In most countries, husbands are typically older than their wives, although the extent of the age gap varies widely across regions. The average age gap between spouses tends to be smaller in Latin America and Asia than in Northern and sub-Saharan Africa, although all regions have recently experienced a narrowing of this gap.

21. In general, as women's education improves, a trend towards later transition to motherhood, fewer children and reduced unwanted pregnancies can be observed. Changing gender norms and attitudes have played a crucial role in the second demographic transition that advanced industrialized societies have experienced in the past decades. Besides a low level of fertility, this new demographic stage encompasses broad changes in the centrality of the family for individuals, reflected in the postponement of marriage, increases in non-marital cohabitation, rising divorce rates and increased levels of out-of-wedlock childbearing. The prevailing view is that the increasing similarity of male and female educational levels and of labour force participation has induced important changes in the family sphere.

22. An increasing number of countries have reached fertility levels below replacement, first in the more developed regions and lately in some less developed regions, particularly in Eastern and South-eastern Asia. According to the *1998 Revision* of the United Nations population estimates and projections,[16] 61 countries of the world, accounting for 44 per cent of the global population, currently have a fertility level that is at or below replacement. However, in many of these societies, survey data indicate that desired family size, typically about two children, is higher than achieved fertility, indicating a latent demand for more children. According to the *1998 Revision*, there are 13 countries with fertility levels at about or below 1.5 children per woman, mostly in Eastern and Southern Europe. Some researchers have suggested that the gap between desired and actual fertility is partly due to inadequate institutional adaptation to changes in gender roles and insufficient provisions to mitigate the potential conflicts women and men face in order to combine economic independence and the rearing of children.

23. The timing of the transition to parenthood has important implications for subsequent reproductive life, including final completed family size, mother's and children's health and family well-being. The prevalence of very early childbearing — before age 15 — is generally low in most countries, although in some sub-Saharan African countries, such as Liberia, Mali and Nigeria, as well as in Bangladesh, about one tenth of young women have a child before that age. Bearing a child before age 18, however, is a common experience in many developing countries, although a recent trend towards a later onset of childbearing has been documented in most regions of the world. The large majority of studies have focused on the detrimental consequences of early childbearing for women, mainly because male adolescent parenthood is not frequent in most societies. However, men are also likely to be ill prepared to assume the full responsibilities of child-rearing at an early age. The few studies available show that, although the effect is weaker than for women, teenage parenthood negatively affects men's educational and occupational careers as well.

24. Most first births occur within marriage, but in some societies a considerable proportion of young women give birth outside the context of marriage. In the sub-Saharan African region, for instance, the proportion of first births to women aged 20-24 that have occurred before marriage reaches approximately 40 per cent in Kenya and Liberia, and exceeds 70 per cent in Botswana and Namibia. While a declining trend of adolescent fertility rates has been documented in most parts of the world, the proportion of non-marital births is on the rise in many countries, both in less developed and in more developed regions. Recent studies based on data from the European Fertility and Family Surveys indicate, for example, that, among mothers aged 25-29, the proportion who have had their first birth outside marriage is about one half in Sweden, Austria and France and about one third in Norway, Germany and the United Kingdom of Great Britain and Northern Ireland. A large proportion of non-marital births occur, however, within a cohabitational union and therefore their recent rise does not necessarily indicate an upward trend towards lone motherhood.

25. Although normally the decision to use contraception falls to both partners, women tend to bear most of the responsibility for pregnancy prevention. One contributing factor to the greater responsibility of women in this domain is that most modern contraceptives rely upon women to initiate and control their use. United Nations recent estimates of contraceptive prevalence rates indicate that 58 per cent of all married couples practise contraception at the world level and that, among those couples, less than one third rely on a method that requires male participation (condom and vasectomy) or cooperation (rhythm and withdrawal) (table 1). Reliance on male-oriented methods is greater in more developed regions (about 50 per cent of overall contraceptive use) than in less developed regions (about 20 per cent). These differentials are partly due to the greater use of periodic abstinence and withdrawal in more developed regions, particularly Eastern and Southern Europe.

Table 1
World and regional averages of current levels of contraceptive use,[a] by method type
(Percentage)

		Female-oriented methods				*Male-oriented methods*		
Major area	*Total*	*Pill*	*IUD*	*Other supply methods*[b]	*Female sterilization*	*Male sterilization*	*Condom*	*Rhythm, withdrawal*[c]
World	58	8	13	3	19	4	4	8
More developed regions	70	17	6	2	9	5	14	19
Less developed regions	55	6	14	2	21	4	2	5
Africa	20	7	4	2	2	0.1	1	4
Asia[d]	60	5	17	2	24	5	3	4
Latin America and the Caribbean	66	14	7	2	28	1	4	9
Oceania	29	5	1	6	9	0.2	1	7

Source: *World Contraceptive Use 1998*, wall chart (United Nations publication, Sales No. E.99.XIII.4).

Note: IUD = intrauterine device.

[a] Levels of contraceptive use among currently married women of reproductive age, including, where possible, those in consensual unions.
[b] Including injectables, diaphragms, cervical caps and spermicides.
[c] Including also total sexual abstinence if practised for contraceptive reasons, folk methods and other methods not separately reported.
[d] Excluding Japan.

26. The increasing prevalence of sexually transmitted diseases, particularly HIV, has made disease prevention a concern as important as unwanted pregnancy, particularly among sexually active young people. These dual concerns are likely to affect contraceptive choices. They have also made more salient the importance of men's shared responsibility in contraceptive behaviour, since the main method that can protect from both unintended pregnancy and disease, namely, the condom, requires men's cooperation. At the world level, the level of condom use remains low. According to United Nations estimates, about 4 per cent of all couples rely on condoms, ranging from 2 per cent in less developed regions to 14 per cent in more developed regions. Available estimates, however, are based on survey responses of married women, and may underestimate the actual levels of use in the overall population.

27. The influence of men on contraceptive decision-making has long been acknowledged, but it is mainly during the past decade that an explicit focus on men as key partners in reproductive health has emerged and shaped policy approaches. Family planning programmes, traditionally oriented almost exclusively towards women, are increasingly regarding men as important and interested participants, and reorienting their services accordingly. Survey data have not supported earlier presumptions about men's having little interest in sharing responsibility for family planning. Recent studies have also shown the large influence of couple communication on contraceptive behaviour.

28. The crucial role played by education in societies' economic and social progress and individuals' well-being is universally recognized. Large educational differentials between men and women tend to sustain and perpetuate gender inequality within the family and in society at large. Conversely, educational parity contributes to the gradual erosion of the

rationale for highly asymmetric gender roles in the domestic and public spheres. Towards this end, the Programme of Action strongly emphasized the value of education for girls. Specifically, the Programme aims at keeping girls and adolescents in school with a view to closing the gender gap in primary and secondary school education by the year 2005.

29. The direct and indirect pathways through which female education exerts its influence on family formation and reproductive behaviour are numerous. Higher education is associated with later age at marriage and later transition to motherhood. With regard to family-size aspirations, better-educated women tend to prefer smaller families, because education expands women's roles beyond child-rearing and prompts greater aspirations for children's education, deterring high fertility. Female education affects not only the demand for children, but also the willingness and ability to implement family-size preferences through contraceptive means. Several studies have shown that education is associated with increased awareness, acceptability and use of contraception. As a result of these processes, unintended childbearing is less frequent among better-educated women, suggesting that education enables reproductive choice. Research findings also suggest that both women's education and men's education are relevant to the process of family formation, and that they reinforce, rather than substitute, for each other.

30. In 1996, 16 per cent of the male population and 29 per cent of the female population over age 15 were illiterate (table 2). Data on enrolment ratios suggest that educational attainment is largely conditioned by a society's level of socio-economic development and that larger gender gaps in schooling are observed in regions with lower overall levels of education. In the past few decades, most regions have experienced an expansion of primary education, except sub-Saharan Africa. In this region, progress began to slow in the 1980s because of economic crisis and debt restructuring, which resulted in higher school costs for parents as well as declines in school quality. In the developing countries as a whole, the gender gap at the primary level has narrowed significantly, although it persists in sub-Saharan Africa, Northern Africa and Southern Asia. Female representation decreases at the secondary and post-secondary levels but the gender gap has narrowed.

Table 2
Male and female illiteracy rates and gross enrolment ratios, 1980 and 1996

	Percentage of illiterate adults				*Gross enrolment ratios*							
					Primary level				*Secondary level*			
	1980		*1996*		*1980*		*1996*		*1980*		*1996*	
Major area	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*
World	23	38	16	29	103	88	105	95	52	41	63	55
More developed regions	2	5	1	2	101	101	103	103	89	90	99	102
Less developed regions	31	53	21	38	104	86	106	94	42	28	55	45
Least developed countries	52	75	41	62	77	54	79	61	20	9	23	15
Africa	48	72	34	54	89	69	85	71	27	16	36	30
Asia	28	51	19	37	106	87	110	98	46	32	62	50
Latin America and the Caribbean	18	23	12	15	106	103	116	110	44	45	55	60

Source: *UNESCO 1998 Statistical Yearbook* (Paris and Lanham, Maryland, United States of America, UNESCO Publishing and Bernan Press, 1998).

31. An increasing number of Governments consider that adolescent boys and girls need better information about reproduction, sexually transmitted infections (STIs), HIV infection, the risk of early childbearing, and the health benefits to be derived from contraceptive use. Even among those who are strong proponents of universal sex education for young people, there is genuine disagreement about the age at which such instruction should begin, who should provide it and the context in which it should be undertaken. In more developed countries in which schooling is continued into the mid- and late teens, it is generally assumed that schools are the best setting for sex education classes, closely followed by youth institutions. Most schools in developed countries offer some kind of sex education to young people in the early years of secondary school. In some developed countries, family-life education is slowly introduced at the very early grades and the content is tailored to children's emotional and cognitive development stages. In most developing countries, however, few boys and girls receive sex education.

32. The Programme of Action of the International Conference on Population and Development emphasized that "Governments should strictly enforce laws to ensure that marriage is entered into only with the free and full consent of the intending spouses. In addition, Governments should strictly enforce laws concerning the minimum legal age of consent and the minimum age at marriage and should raise the minimum age at marriage where necessary" (para. 4.21). In many parts of the world, women's basic human rights are violated when they are given in marriage without their consent, or where family pressure results in coerced consent. Laws establishing a minimum age at marriage are nearly universal, with the most common minimum ages being 18 for males and 16 for females.

33. A problem with many laws establishing a minimum age at marriage is that they are set too low for women and are lower for women than for men, suggesting that women need fewer years to prepare for marriage, as their duties will be confined to childbearing and domestic roles. Over the past two decades, more than 50 countries have altered their laws on the minimum legal age for marriage. However, age-at-marriage laws are often not enforced. In some parts of the world, such as in Africa, the legal age for marriage is often high, yet actual age at marriage is low. In many countries, the minimum legal age at marriage with parental consent is considerably lower than that without such consent.

34. Many family planning programmes in the past paid little attention to men. Moreover, some family planning programmes even avoided men because they assumed that men were indifferent, or even opposed, to family planning. The Programme of Action formally recognized the importance of men to women's reproductive health and also recognized the importance of men's own reproductive health. The Programme of Action urges all countries to provide men, as well as women, with reproductive health care that is "accessible, affordable, acceptable, and convenient." It encourages reproductive health care programmes to move away from considering men and women separately and to adopt a more holistic approach that includes men and focuses on couples. A number of countries have developed programmes for men in recent years.

35. During the historic fertility transitions in Europe and Northern America, the primary methods of fertility limitation — withdrawal, abstinence and the condom — were controlled by men. Since the "contraceptive revolution" in the 1960s, when the pill became widely available, most advances in contraceptive technology have been in hormonal methods for women. Although many women may prefer long-acting devices for reasons of comfort, or because their husbands need not be informed, they become dependent upon health systems that are often insufficiently equipped to meet medical requirements. Legal or administrative requirements still limit access to a wide range of family planning methods in some countries,

and in some places women are required to obtain permission from husbands or parents before they can obtain services.

36. There is a striking sex difference with regard to sterilization. In most countries, female sterilization is still much more widely performed than male sterilization, even though the surgical procedure for women carries greater risk, requires more technical experience and is more expensive than sterilization for men. Indeed, female sterilization is the single most important method for the world as a whole, accounting for about 30 per cent of total contraceptive practice. Since 1974, there has been a trend throughout many areas of the world to reduce or remove restrictions on voluntary sterilization. However, in order to avoid abuse and in light of the irreversibility of the method, many Governments set age, parity and other requirements for who may obtain voluntary sterilization. Many countries impose restrictions on women but not on men.

37. A number of countries in Eastern, South-eastern and South-central Asia in particular have had a long and deeply held tradition of preferring male children. There are many bases of this phenomenon, including belief in the greater suitability of sons for difficult agricultural work, the ability of sons to carry on the family name and bloodline, the necessity of providing daughters with sizeable dowries when they marry, and ingrained cultural beliefs. If a couple desires to have only one or two children, they often would like to ensure that these children are male. To counteract the practice of prenatal sex selection, the Government of India enacted country-wide legislation in 1994 that regulates prenatal testing. The stated purpose of the legislation is to prohibit the use of prenatal diagnostic techniques for the determination of the sex of a foetus, resulting in "female foeticide".

II. Health and mortality

38. The world has experienced remarkable reductions in mortality during the twentieth century. In the second half of the century alone, global life expectancy at birth increased from 46.5 years in 1950-1955 to 65.4 years in 1995-2000 (table 3). In the more developed countries, where substantial increases in longevity had already occurred by 1950, life expectancy at birth has increased from 66.6 to 74.9 years since the early 1950s. In contrast, most countries in the less developed regions did not begin to experience mortality declines until after 1950; however, their transition thereafter was more rapid. Life expectancy at birth in the less developed regions is estimated to have jumped an impressive 22.4 years, from 40.9 years in 1950-1955 to 63.3 in 1995-2000. Even among the least developed countries, life expectancy increased by 14.9 years, from 35.6 years to 50.5 years.

39. The decline in mortality during the twentieth century has been attributed to a number of factors, including increases in income and nutritional intake, advances in sanitation and water supply, and disease prevention and public-health reforms that improved living conditions. In the less developed regions where the key feature of the mortality transition is a massive reduction in infant and child mortality in the second half of the twentieth century, public-health programmes have played a major role. Of particular importance has been the application of new technologies in disease prevention and management.

40. Mortality decline has also been strongly linked to the expansion of educational opportunities. Education, in particular that of women, has been shown to have effects on infant and child mortality that are larger than the combined effects of income, improved sanitation, and modern sector employment. A recent study of the sources of the global mortality decline attributed one third of the increase in male and female life expectancy between 1960 and 1990 to gains in the educational attainment of females.

Table 3
Trends and sex differentials in life expectancy at birth, world and major areas, 1950-1955, 1975-1980 and 1995-2000

	Life expectancy, both sexes (years)			*Sex differential (female-male life expectancy)*		
Major area	*1950-1955*	*1975-1980*	*1995-2000*	*1950-1955*	*1975-1980*	*1995-2000*
World	46.5	59.7	65.4	2.7	3.5	4.4
More developed regions	66.6	72.1	74.9	5.0	7.4	7.6
Less developed regions	40.9	56.8	63.3	1.7	2.0	3.2
Least developed countries	35.6	45.3	50.5	1.3	1.8	1.9
Africa	37.8	48.0	51.4	2.7	3.2	2.8
Asia	41.3	58.5	66.3	1.4	1.6	3.1
Europe	66.2	71.2	73.3	5.1	7.7	8.2
Latin America and the Caribbean	51.4	63.1	69.2	3.4	5.2	6.5
Northern America	69.0	73.3	76.9	5.8	7.8	6.6
Oceania	60.9	68.2	73.8	3.8	5.6	4.9

Source: World Population Prospects: The 1998 Revision, vol. I, *Comprehensive Tables* (United Nations publication, Sales No. E.99.XIII.9).

41. Although most of the factors accounting for twentieth century mortality declines have improved the living conditions of both males and females, life expectancy has increased faster for females everywhere and female life expectancy at birth in 1995-2000 exceeds that of males in nearly all countries. Globally the female advantage in life expectancy at birth in 1995-2000 is estimated to be 4.4 years, but the differential is larger in the more developed regions (7.6 years) than in the less developed regions (3.2 years). The least developed countries exhibit even smaller differentials of about 1.9 years.

42. Among the developed countries, the sex differential in life expectancy is smallest — less than five years — in Iceland, Malta, Sweden and the former Yugoslav Republic of Macedonia. The largest sex differentials— greater than 11 years — are estimated for Belarus, Estonia, Latvia, Lithuania and the Russian Federation. The higher levels of mortality and the large sex differentials in life expectancy in Eastern Europe reflect the prolonged stagnation and reversals of mortality decline that have occurred in that region since the mid-1960s, particularly among males.

43. Sex differentials in life expectancy in the more developed regions are mainly due to differential trends in adult and old-age mortality inasmuch as infant and child mortality in those regions have long ceased to have a significant impact on life expectancy. An examination of sex differentials in age-specific mortality rates over age 30 for selected developed countries shows a large male disadvantage at every age in all countries. This disadvantage is generally largest in Eastern European countries. Excess male mortality is most pronounced between the ages of 30 and 40.

44. Differences between male and female life expectancy in the less developed regions are, in general, smaller than those in the more developed regions, although there are developing countries with differentials in mortality that parallel those in the more developed regions. The smallest sex differentials in the less developed regions occur in South-central Asia, where life expectancy was slightly higher for men than for women before 1980, but

where females now experience a 1.1 year advantage. The largest sex differentials are estimated for South America and Southern Africa where the female advantage is 6.5 and 6.0 years, respectively.

45. Much of the literature addressing sex differentials in mortality in developing countries has focused not so much on the differentials in life expectancy, which can be biased by the assumptions made in estimating adult mortality for countries with limited data, as on sex differentials in childhood mortality, that is to say, infant, child and under-five mortality, for which more data are available. In most populations, female infants experience lower mortality than their male counterparts, an outcome that is attributed to biological and genetic factors (see table 4). The female advantage also operates beyond infancy, although at some point during early childhood, between ages 1 and 4, environmental rather than biological factors begin to have a greater influence in determining sex differentials in mortality. In some countries, the advantage that girls have over boys is outweighed by other factors, including discrimination against girls in a way that affects their health and survival.

Table 4
Infant and child mortality estimates, world and major areas, 1995-2000

Major area	*Infant mortality rate (per 1,000 births)*	*Probability of dying by age 5 (per 1,000 births)*		
		Total	*Male*	*Female*
World total	57	80	80	80
More developed regions	9	11	13	10
Less developed regions	63	87	87	88
Least developed countries	99	156	160	151
Africa	87	140	146	133
Asia	57	74	71	77
Europe	12	14	16	12
Latin America and the Caribbean	36	44	49	39
Northern America	7	8	9	7
Oceania	24	32	31	32

Source: World Population Prospects: The 1998 Revision, vol. I, *Comprehensive Tables* (United Nations publication, Sales No. E.99.XIII.9).

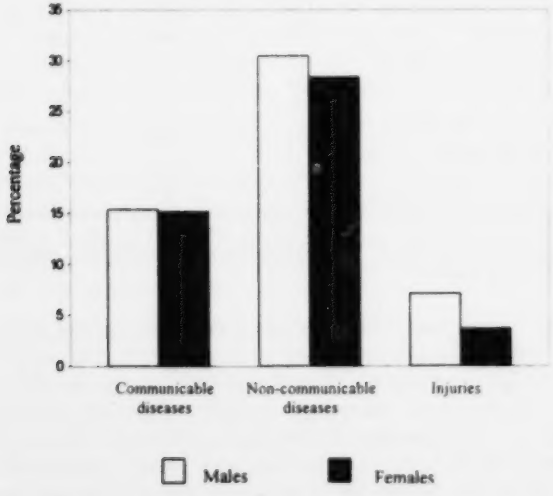
46. A recent study by the United Nations of sex differentials in infant and child mortality and their determinants in developing countries in the 1970s and 1980s confirmed a lower probability of survival among male than among female infants in the majority of countries studied. With respect to child mortality (the probability of dying between ages 1 and 5), the study found evidence of excess female mortality that was not confined to any single region. A weighted average for all countries revealed an excess female child mortality on the order of 10 per cent. At the regional level, girls were found to be most severely disadvantaged in South-central Asia and to a lesser extent in Northern Africa and Western Asia. In all other regions, the countries experiencing higher female than male child mortality failed to display clear-cut geographical patterns, although in Latin America and the Caribbean they tended to cluster in Central America and in sub-Saharan Africa they tended to fall within Western and Central Africa. In most of those countries, however, the female disadvantage was small.

47. Recent data for the 1990s show that, although infant and child mortality has continued to decline for both boys and girls, excess female child mortality is still prevalent in some countries. Girls continue to be most severely disadvantaged compared with boys in South-central Asia and to a lesser extent in Northern Africa and Western Asia.

48. In examining the determinants of excess female child mortality, the United Nations study did not find a systematic neglect of girls in terms of nutrition even in countries where there is clear evidence of a female disadvantage in survival. The findings were somewhat more mixed with respect to the use of health services. In countries where girls were most severely disadvantaged, there was evidence of discriminatory practices in regard to access to both preventive and curative care. Surprisingly, there was no consistent evidence that the education of mothers mediated sex differentials in the prevention and treatment of sickness even though education has been shown to have considerable impact on child survival. Overall, the findings of the study showed that the determinants of excess female child mortality were complex and no conclusive evidence on the exact causes could be found, thus underscoring the importance of caution against oversimplified interpretations of excess female mortality as being the result of gender discrimination.

49. With regard to causes of death, global estimates of the distribution of deaths in 1998 by sex and three broad cause groups (figure I) show that non-communicable diseases are, by far, the most important causes of mortality for both males and females, accounting for about 59 per cent of all deaths in 1998. Thirty per cent of deaths are estimated to have been due to communicable diseases and 11 per cent due to injuries.

Figure I
Distribution of deaths by sex and broad cause groups, world, 1998



Source: World Health Organization, *The World Health Report 1999: Making a Difference* (Geneva, 1999), annex table 2.

50. Although the data shown in figure I suggest that males and females are almost equally likely to die from communicable and from non-communicable diseases, there are important sex differences in mortality from specific causes. Among communicable diseases, males are more likely than females to die from infectious and parasitic diseases. Tuberculosis alone accounted for 49 per cent more deaths among males. Among non-communicable diseases, cardiovascular diseases and malignant neoplasms are the most important causes of death for both males and females. It is estimated that 32 per cent more males than females die from malignant neoplasms. Among women, cancers of the breast and the reproductive system account for the largest number of deaths from cancer.

51. Female deaths exceed male deaths from cardiovascular causes. The primary source of the excess female deaths from cardiovascular disease is mortality at age 70 years and above, where female deaths exceed male deaths by 36 per cent. In contrast, at ages 30-59, male deaths from cardiovascular diseases exceed female deaths by more than 50 per cent. This suggests that cardiovascular diseases have become the primary cause of mortality among females, not because women are more vulnerable, but because more of them survive to the ages where cardiovascular diseases are the primary causes of death.

52. Injury is an important cause of death among younger men. Of an estimated 5.8 million deaths due to injury in 1998, 3.8 million or two thirds occurred among men. More than twice as many men as women die from road traffic accidents. Deaths due to homicide and violence are also nearly four times as common among men as among women.

53. The factors that account for higher male than female mortality from most communicable diseases are not clearly understood, although it appears that inherent sex differences in biology, reinforced by differences in the socialization of males and females, contribute to the sex differentials. For non-communicable diseases and injuries, there is considerable evidence indicating the importance of behavioural factors in contributing to sex differentials in morbidity and mortality. In Eastern European countries, risky behaviour among males, notably excessive use of alcohol and smoking, has been implicated. Tobacco use is associated with considerably higher mortality risks among males than females. At the global level, tobacco-related mortality is estimated to be four times higher for men than for women. Since current deaths relate to past consumption, and the prevalence of smoking among women has increased in recent years, it is expected that the health consequences will expand to include a larger number of women. Already lung cancer is the most common cause of cancer deaths among women in the United States of America and its incidence is rising in countries where female smoking is long-established. As more women have adopted smoking, tobacco-related morbidity and mortality have become major threats to the continued female advantage in life expectancy.

54. Complications related to pregnancy and childbirth continue to be among the leading causes of mortality for women of reproductive age in many parts of the developing world. According to recent estimates by the World Health Organization (WHO), about 500,000 women died from pregnancy-related causes in 1998, with more than 99 per cent of those deaths occurring in low- and middle-income countries. Although there is evidence that maternal mortality has declined in countries where the overall mortality is low, it is difficult to measure progress in those countries where the problem is thought to be most acute because of the lack of reliable data. The immediate cause of pregnancy-related complications, ill health and death is insufficient care of the woman during pregnancy and delivery. Factors that contribute to high maternal mortality include women's subordinate status, poor health and inadequate nutrition. Lack of education and deficient or incorrect information about signs of complications during pregnancy also contribute to the high maternal mortality in developing countries.

55. Attempts to mainstream the gender perspective in health policy are at an early stage of implementation. While some progress has been made in identifying priority areas, mobilizing resources for incorporating a gender perspective has turned out to be a difficult exercise in many countries, especially developing countries, where health systems face serious structural and financial difficulties and are undergoing major reforms. Efforts to mainstream gender in the health sector have focused largely on women's health issues. Examples of gender-sensitive policies and programmes that deal with other aspects of health are scarce. Interventions aimed at promoting health and preventing lifestyle-related conditions, such as anti-smoking campaigns, provide a striking example of this absence of gender perspective. It is now well established that behavioural patterns such as nutritional habits, smoking and alcohol consumption that have a strong bearing on the health of both individuals and populations, are often gender-specific. However, with the exception of campaigns targeting pregnant women, anti-smoking campaigns have not taken gender into account. Similarly, alcohol prevention campaigns are almost never gender-specific, although many rehabilitation programmes have, implicitly, been aimed at men.

56. Over two thirds of the Governments of developing countries, as well as one half of the Governments of developed countries, that have replied to the Eighth United Nations Inquiry on Population and Development view their level of maternal mortality as unacceptably high. All countries indicate that they have taken measures to reduce these levels. The majority of measures taken by Governments pertain to the area of prenatal care and information, education and communication. Whereas interventions to reduce maternal mortality and morbidity rest on the rationale that the single most important proximate determinant of maternal health and survival is the extent to which women have access to essential obstetric care, information on governmental actions points to the fact that emergency obstetric services are not receiving the highest priority. In addition, research findings suggest that programmes such as those for the training of traditional birth attendants, have had, so far, a modest impact on maternal mortality in much of the developing world. It is becoming increasingly clear that the efficiency of interventions aimed at reducing maternal mortality is conditioned by the overall strengthening of the health care system.

57. The Programme of Action calls for the elimination of all forms of violence against women, including domestic violence and female genital mutilation. Most countries have only recently embarked on the formulation of lines of action for the detection and prevention of domestic violence. Latin America is one region where significant developments have recently taken place. All seven countries of Central America passed domestic violence legislation between 1995 and 1997. A number of countries have also established special police force units to deal with gender-based violence and violence within the family (Argentina, Brazil, Nicaragua and Peru). Interventions to improve detection by targeting vulnerable populations such as adolescents or by being based on risk criteria have been attempted within schools and health-care facilities but, as yet, are difficult to assess. In large cities, telephone hotlines have also been established either within the public services or by non-governmental organizations, with a view towards reaching out to victims of domestic abuse. A number of non-governmental organizations have also opened shelters, as well as raised funds in order to provide short-term economic support to abused women. In regard to care, a number of both developed and developing countries have established standards and protocols for biomedical and mental interventions aimed at victims of domestic violence and sexual abuse. Among these attempts, Malaysia's "One Stop Centres" hospital programme initiative stands out as an innovative and sensitive approach to the treatment of domestic violence.

58. The strong consensus achieved against the practice of female genital mutilation at recent international conferences has fuelled national and international initiatives aimed at putting an end to this practice. A number of African States have passed legislation prohibiting and/or criminalizing the practice of female genital mutilation: Ghana (1994), Burkina Faso (1996) and Côte d'Ivoire (1998). In 1997, the highest Egyptian administrative court overturned a lower court ruling that had rejected a governmental decree issued in 1996 that banned the practice by health workers of female circumcision. Most countries have attempted to address the issue through means other than criminal statutes such as discouragement of the practice through information campaigns stressing its harmful consequences for health. Among these activities, the alternative, non-harmful rites that have been carried out by non-governmental organizations in partnership with traditional chiefs, in four districts of Kenya and in the Kapchorwa region of Uganda, stand out as constituting an innovative communications approach. Several countries with African immigrant populations – Australia, Canada, Denmark, France, the Netherlands and Norway as well as the United States of America in eight States — have either passed legislation against female genital mutilation or made it clear that this practice was illegal under criminal law.

HIV/AIDS

59. By the end of 1999, 33.6 million people were estimated to have been infected with HIV (table 5). Over the course of the year, some 6.6 million people became infected with HIV. More than 95 per cent of all HIV-infected people live in the developing world. Ninety-five per cent of all AIDS deaths also occur in developing countries, largely among young adults who would normally be in their peak productive and reproductive years. The AIDS epidemic has so far claimed the lives of more than 16 million people.

60. By the end of 1999, men accounted for 54 per cent of all people over age 15 living with HIV/AIDS. One of the most disturbing trends of the HIV/AIDS epidemic is the increasing toll of HIV/AIDS on women and girls. In Africa, the majority of HIV-positive adults are women. In some of the worst affected countries, HIV-infected women outnumber men by as much as 16 to 1 in the younger age groups. Furthermore, there are no indications that this trend will improve.

61. Why more women than men are infected is not fully understood. A combination of factors are clearly involved, including the fact that HIV passes more easily through sex from men to women than from women to men. However, a prime factor is surely the difference in age patterns of HIV infection in men and women. Women tend to become infected far younger than men for both biological and cultural reasons. According to recent studies in several African populations, girls aged 15-19 are about five or six times more likely to be HIV-positive than boys their own age. The infection rate in men eventually catches up, but not until after they reach their late 20s or early 30s. Clearly, older men — who often coerce girls into sex or buy their favours with sugar-daddy-type gifts — are the main source of HIV among teenage girls.

62. Saying no to unprotected sex is a serious challenge for young women who are economically or socially dependent on their male partners, fear violent consequences and have weak negotiating positions for protected sex. Local myths and beliefs encourage older, more sexually active men to seek younger sexual partners, thus accounting for increased incidence of sexually transmitted diseases (STDs) and HIV infections among younger girls compared with boys their own age. Moreover, in some countries women are becoming sexually active at a younger age, unaware of the risks of HIV and STDs.

Table 5
Regional HIV/AIDS statistics and features, December 1999

Region	*Epidemic started*	*Adults and children living with HIV/AIDS*	*Adults and children newly infected with HIV*	*Adult prevalence rate[a] (percentage)*	*Percentage of HIV-positive adults who are women*	*Main mode(s) of transmission for adults living with HIV/AIDS*
Sub-Saharan Africa	Late 1970s Early 1980s	3 300 000	3 800 000	8.0	55	Hetero
Northern Africa and Western Asia	Late 1980s	220 000	19 000	0.13	20	IDU, Hetero
Southern and South-eastern Asia	Late 1980s	6 000 000	1 300 000	0.69	30	Hereto
East Asia and the Pacific	Late 1980s	530 000	120 000	0.068	15	IDU, Hetero, MSM
Latin America	Late 1970s Early 1980s	1 300 000	150 000	0.57	20	MSM, IDU, Hetero
Caribbean	Late 1970s Early 1980s	360 000	57 000	1.96	35	Hetero, MSM
Eastern Europe and Central Asia	Early 1990s	360 000	95 000	0.14	20	IDU, MSM
Western Europe	Late 1970s Early 1980s	520 000	30 000	0.25	20	MSM, IDU
Northern America	Late 1970s Early 1980s	920 000	44 000	0.56	20	MSM, IDU, Hetero
Australia and New Zealand	Late 1970s Early 1980s	12 000	500	0.10	10	MSM, IDU
Total		**33 600 000**	**5 600 000**	**1.10**	**46**	

Source: Joint and United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) (UNAIDS)/World Health Organization, *AIDS Epidemic Update: December 1999* (Geneva, December 1999).

Note: "Hetero" denotes heterosexual transmission, "IDU" denotes transmission through injecting drug use and "MSM" denotes sexual transmission among men who have sex with men.

[a] Proportion of adults, 15-49 years of age, living with HIV/AIDS in 1999, using 1998 population numbers.

63. Unequal gender relations that limit the ability of young women to adequately protect themselves from HIV infection are rooted in socio-economic conditions where many women face discrimination from birth onwards. Women are generally less educated than their male counterparts, lack economic opportunities and access to productive resources, and have limited access to sexual and reproductive health information. A woman's biological vulnerability to HIV is compounded by these gender-related inequalities and inequities.

64. Women are affected disproportionately by HIV/AIDS. When new household, business or family farm duties arise because family members are ill, it is girls who are pulled first from school and find themselves particularly vulnerable with respect to bartering sex for cash or other resources. Women as primary caregivers are increasingly burdened with the care of AIDS orphans of their extended family and often assume roles as household heads, facing constraints caused by larger socio-economic disparities. Household food security is increasingly at risk in agricultural communities where women who are responsible for

subsistence farming are falling ill. Meanwhile, when women in poverty fall sick, they have less access to health care than men. Or, in many cases, they prefer not to seek care services, being fearful of the social stigma and discrimination and alienation from their families.

65. Rural-urban migration for employment continues to be linked to the spread of HIV. At a distance from their marriage and family ties, men seek other sexual partners, largely around their worksites, thereby endangering not only themselves, but also these women. When they return to their rural households and re-establish sexual relationships, they increase the possibility of HIV transmission's being carried back to their wives and home communities.

66. While the entry of women and adolescents in developing countries into the productive economic sectors, such as manufacturing and tourism, either as the main family breadwinner or to augment the family income, is a positive step towards increasing their economic independence, this migration presents new challenges for them. Many of them form new sexual networks without the protective and supportive features of families and village communities, thus increasing their vulnerability to STD and HIV infection.

67. In high-prevalence countries, HIV/AIDS has set back development efforts. In countries where the epidemic has spread to the general population, declines in life expectancy of between 10 and 20 years are estimated. Lack of improvement in child mortality, as a result of mother-to-child transmission, will likewise be a component of a declining development scenario in these countries. One tenth of the newly infected people in 1999 have acquired their infection through their mother.

68. HIV/AIDS will clearly affect the infrastructure of already stretched and overburdened health-care systems. Increased expenditures of public-health budgets for AIDS treatments, particularly in Africa, are projected to be between 35 and 65 per cent. Loss of trained staff and other health-care providers will also seriously impair the standard and quality of health care in Africa.

69. Increasing orphanhood is one of the saddest aspects of the epidemic. By the end of 1999, 11.2 million children under age 15 were orphaned by AIDS, 95 per cent of whom live in sub-Saharan Africa. Extended family structures, already stressed by urbanization and labour migration, are unable to perform their traditional role as coping mechanisms. It is also unlikely that social and welfare services in many countries in the region will have the capacity to provide the care and support for these large numbers of orphaned children.

70. Three major lines of action for improving the prevention and treatment of STDs and HIV/AIDS have been pursued: integrating STDs and HIV/AIDS services into existing primary and community-based health services, developing new technology, and promoting gender equality in sexual and family relationships. Integrating services has been promoted as a mean of removing gender-related barriers to receiving treatment and making STD and HIV/AIDS services available and accessible to more people than are currently being served, especially sexually active unmarried women and adolescent girls. In developing countries, the provision of these services has been limited to the few antenatal clinics that make up the national HIV surveillance system. In several countries, efforts by national family planning associations to supplement governmental efforts have been significant.

71. New technologies are also becoming available that have a potential for helping women protect themselves. The female condom is now marketed in more than 30 countries and is gaining recognition inasmuch as it both gives women personal control in the sex act and enhances women's capacity to protect themselves from STDs and HIV/AIDS. In the past five years, the number of microbicidal products being tested has increased considerably.

However, field trials of existing intra-vaginal microbicidal products have been somewhat disappointing.

72. A majority of countries have embarked on information and communication campaigns promoting gender equality in sexual and family relationships. In a number of countries, attempts have been made to link training programmes on relationship skills with the promotion and distribution of condoms. Peer education has also proved to be effective in targeting specific groups of men and women. In addition, a few attempts have been made to go beyond traditional prevention activities and to address the economic roots of gender vulnerability.

III. Ageing and gender

73. Population ageing is, in basic demographic respects, not "gender-neutral". The evolution to an older age structure changes the balance in numbers of men and women in the whole population. At ages 60 years and above, there are currently 334 million women and 271 million men, or 1.2 women for each man (table 6). The ratio increases from 1.1 women per man at ages 60-69 years to 1.8 women per man for those in their 80s, to 2.9 women per man for those in their 90s and to 4 women per man among centenarians. This female majority at high ages contrasts with the pattern at younger ages, where males predominate. This is because more boys are born than girls — on average around 105 boys for every 100 girls. However, because mortality rates are, with few exceptions, higher for males, women come to predominate at the older ages. For the world as a whole, women outnumber men at all ages above 54 years.

Table 6
World population aged 60 years or over by sex and ratios of older women to older men, 2000 and 2050
(Millions)

	2000			*2050*		
Age group	*Women*	*Men*	*Ratio (women/men)*	*Women*	*Men*	*Ratio (women/men)*
60 years or over	334.3	270.9	1.2	1 063.3	906.5	1.2
60-69 years	176.6	161.8	1.1	482.1	467.2	1.0
70-79 years	112.2	85.1	1.3	351.1	299.1	1.2
80-89 years	39.5	22.0	1.8	187.6	123.7	1.5
90-99 years	5.9	2.0	2.9	40.7	16.2	2.5
100 years or over	0.12	0.03	4.0	1.85	0.34	5.4

Source: *World Population Prospects: The 1998 Revision*, vol. II, *Sex and Age* (United Nations publication, Sales No. E.99.XIII.8).

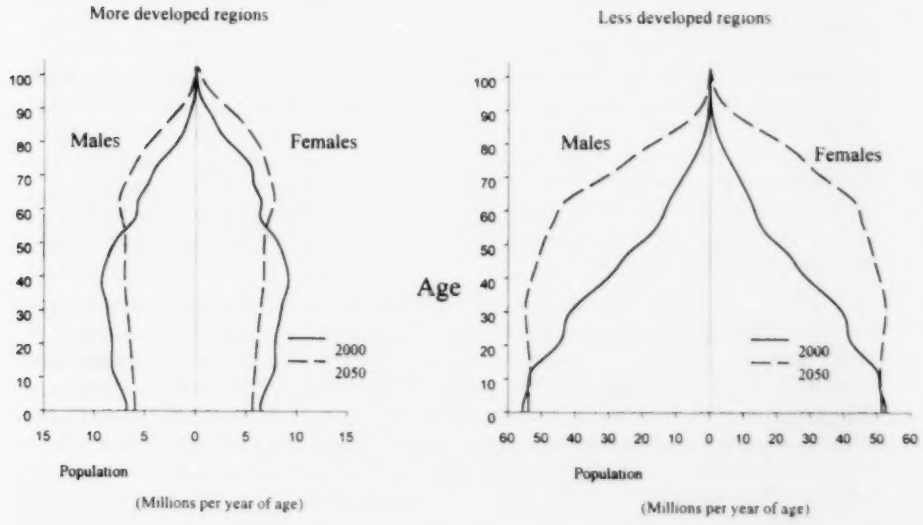
74. The preponderance of women at older ages is greater in the more developed than in the less developed regions, reflecting the greater gender gap in mortality rates in the former group (figure II). The female-to-male ratios are expected to decline slightly at most of the higher ages, though by 2050, older women will still greatly outnumber older men. The absolute number of older women added to the population will also be greater than the number of men: between 2000 and 2050, the female population is projected to increase by

729 million, and the male population by 636 million. While the increased likelihood of surviving to older ages is obviously due to mortality declines at younger ages, recent decades have also seen significant mortality improvements among the older population, including the oldest-old, and these trends so far have been more beneficial to women than to men.

75. Efforts to investigate the health status of older men and women have been hampered by the lack of reliable and internationally comparable data. This situation is attributable to several factors, including problems in determining health status at older ages, the exclusion of older persons from large-scale medical studies, the multiplicity of pathological conditions in old age and pockets of ageism. A life-cycle approach to health and health care is being applied to the health of older persons. This approach stresses the links between health at older ages and lifelong health, stretching as far back as the intrauterine period, and implies that, especially in countries with wide gender inequities, older women's health status is rooted in the discrimination they confront earlier in life, when they have less access than men to health care, adequate nutrition and education.

Figure II

Age and sex distribution of the population, more developed and less developed regions, 2000 and 2050



Source: *World Population Prospects: The 1998 Revision*, Vol. II: *Sex and Age* (United Nations publication, Sales No. E.99.XIII.8).

76. That marital status is an important determinant of health and longevity is a consequence of a number of factors. The fact that married people tend to have lower mortality rates than the unmarried may result from selection (those who marry are healthier), protection (those who marry live healthier lives) or the greater financial security associated with being married. Unmarried older women, particularly in countries where formal support mechanisms are still in their infancy, are more likely to live in poverty than those who are married, and they are thus more vulnerable.

77. At older ages, men are much more likely than women to be married. While more than three quarters (79 per cent) of older men are currently married, less than one half (43 per cent) of older women are married. It appears that socio-economic development does not alter the shares of married and unmarried older persons. The percentages married are virtually identical in more and less developed regions. The large sex differential in marital status results from greater female life expectancy and from wives' being, on average, younger than their husbands. Older women also remarry less frequently than older men, following divorce or spousal death. The number of widows is rising rapidly in most regions.

78. At older ages, living alone is primarily a female experience. Among the member States of the European Union (EU), 15 per cent of older males live alone, compared with 39 per cent of older women. The proportion of older persons living alone in developing countries is much lower than in developed countries, because of the continuing strong tradition of filial piety, often expressed as co-residence of older persons and their children. The significant proportions of older persons living alone in more developed countries may also signify, to some extent, a preference for greater privacy and independence, as well as the availability of the economic means to achieve this.

79. Caregiving is emerging as one of the preeminent issues related to the situation of older persons. Most countries, especially those with inadequate formal support systems, rely almost exclusively on the extended family — which usually means women — to care for older persons. These women are torn between the needs of raising children, caring for ageing parents and, in many cases, engaging in labour- market activities. In countries with formal support systems, the trend towards shifting caregiving from public support to the family has increased the demands on family caregivers. The fact that working women in developed countries are as likely to be caregivers as non-working women dispels the myth that employment outside the home precludes women from becoming caregivers. Although the percentage of older persons in institutions at any given time — about 5 per cent of older persons in developed countries — is relatively low, some 25-30 per cent of older persons are in institutions towards the end of their lives. Women, because they are more likely to survive to older ages, and to be unmarried, and the oldest-old, are the large majority among the institutionalized population.

80. Often overlooked is the smaller but not-negligible proportions of older persons providing financial, physical and material support to their children and/or grandchildren. In a number of countries, grandparents, usually the grandmother, provide a substantial amount of childcare to grandchildren. Furthermore, the number of children living in grandparent-headed households has increased owing to various factors, including HIV/AIDS, divorce, teen pregnancy, drug abuse and migration of parents. Of the 11.2 million AIDS orphans in the world as of the end of 1999, 95 per cent were in sub-Saharan Africa, where grandparents were the main caregivers for many of these children.

81. Older men are more likely than older women to be in the labour force. At the global level in 1995, 42 per cent of older men were economically active, as compared with 16 per cent of older women. In reality, many older persons work until they are too infirm to continue. Sustained economic activity, even at advanced ages, has been reported in Africa and Asia. Actually, the economic contribution of older women is underestimated because definitions of economic activity often exclude major segments of the type of work performed by women. Owing to a lack of both formal education and skills, older women are largely in the informal sector of many developing economies, working on family farms, or in other agricultural enterprises, or taking in piecework. Older women's lower participation rates also reflect the generally earlier retirement age for women in more developed regions. The weakening attachment of older persons to working life is seen in the average age at

retirement which has fallen for both men and women in more developed regions and a retirement period that has grown more sharply for women than for men.

82. For many older persons, especially in less developed regions, poverty is a major threat to well-being. Programmes to improve the situation of older persons in general, and older women in particular, would need to concentrate on income security, food security and health services. However, in the absence of a national pension scheme, such programmes may be difficult to implement. Only Namibia and South Africa have comprehensive national pension plans in sub-Saharan Africa.

83. Women's lifetime earnings are generally substantially lower than those of men, because of shorter and more erratic labour force participation, part-time employment, lower wages, smaller pensions and work in the informal sector. Furthermore, in many countries, women's lower social status, weaker property rights and limited access to inheritance also influence their security in old age. Where pension benefits are based on the husband's entitlement, the economic status of non-working wives deteriorates if they become widowed, as pension benefits are often reduced or terminated upon the husband's death. Nevertheless, pensions have reduced income disparities between older men and women.

84. After the International Conference on Population and Development held in 1994, many government views shifted to a new comprehensive and gender-aware approach towards population ageing. There are countries, such as Austria, Australia, Canada, the Dominican Republic, Ghana, Malawi, the Republic of Korea, South Africa and Sweden, whose policies have been particularly advanced in respect of the development of a gender approach to population ageing. The observance of the International Year of Older Persons in 1999 has offered a further incentive for the application of a gender perspective in government programmes on ageing.

85. In the developed countries, some Governments have taken a number of measures to boost employment among older workers, including a bonus system to reward firms for employing older workers and the charging of a penalty to make firing them more expensive. The Austrian Government seeks to create and preserve jobs for women through labour-market programmes targeted specifically at women, and to develop special measures to support women who return to work after a break in their career or a spell of unemployment. It is also improving old-age pensions for women by giving stronger consideration to specifically female life courses in determining pension levels. In some countries, the development of a new culture of voluntary work plays a special part in the new old-age policy. An examination of standard retirement age by country reveals that men become eligible for full pension benefits at age 65 or over in more than one half the countries, while the most common standard retirement age for women is between 55 and 59 years. In countries where differentials have existed, they are being eliminated or narrowed by raising the age at which women can retire.

86. In some countries, measures have recently been taken to preserve, strengthen and simplify the income security system and to ensure that it remains affordable. In Canada, a new Seniors Benefit and reforms to the Canada Pension Plan have been introduced. They will help target benefits to low- and middle-income seniors and they include special features that accommodate women's child-rearing responsibilities, longer lifespans and unique relationship to the labour market. The Australian Government has taken a number of steps to address possible inequities in superannuation coverage and benefits associated with intermittent working patterns. Also, a widow allowance is provided to women who have become widowed, divorced or separated after turning 50 years of age.

87. Some developing countries are also implementing a mainstreaming of gender in programmes on ageing. Government actions aimed at addressing economic disparities between men and women and empowering older women include improving women's access to credit and training, removing discriminatory customary legislation and facilitating women's involvement in small and medium-sized enterprises. In a number of countries, economic enrichment programmes have been initiated with and for older persons.

88. Inequalities in access to health services, especially primary health care, profoundly influence the health situation of older men and women. Women experience higher rates of chronic illness and disability in later life compared with elderly men who typically suffer from acute conditions. Since health-care delivery is geared towards acute care programmes, it generally ignores the needs of older women who require greater home care, not hospitalization. Many developed countries seek to provide to both older men and older women suffering from chronic illnesses access to in-home assistance services instead of institutionalization. Countries with economies in transition are concerned about high mortality among middle-aged and older men and have recently begun health promotion programmes aimed at promoting healthy lifestyles, particularly among men.

89. An important policy direction of many Governments is the promotion of community participation in older people's health-care and social services. For example, HelpAge India has emphasized educating and recruiting young people and children to work with older people. Similar measures have also been successful in widely different settings, such as in Colombia, Kenya and Sri Lanka. Some Governments encourage older persons to take responsibility for becoming the principal promoters of their own health.

90. There is a rising tendency on the part of Governments in the developed countries to emphasize the role of the family in informal care rather than more formal and institutionalized care. This trend has increased the demand put on informal caregivers, who are mainly women. In Germany, the family is regarded as the source of help of first recourse, and assistance is available from the welfare State only where that has failed. The responsibility of families is, furthermore, encoded in laws. In Austria, priority is given to strengthening and extending intergenerational solidarity. Family members who provide long-term care to disabled or elderly family members and give up their job for this reason have the employer's share of the pension insurance paid from public funds, and this reduces their pension insurance payments by about half. Some other developed countries have also introduced cash payments and care insurance schemes that compensate caregivers for the work they do. The Governments are promoting an equal sharing of caregiving responsibilities between men and women and a better reconciliation of working and caregiving responsibilities.

91. In the developing countries, the traditional method of caring for the elderly has always been through the extended family. The process of modernization and industrialization often erodes the status older women and men used to have in traditional societies. Urbanization is another trend that has weakened traditional support systems for older persons. The decline of these systems affects women and men differently. However, the gender dimension has received very little attention from researchers and practitioners. Policy makers in developing countries are just beginning to address the challenges traditional support systems face. In a number of countries, such as China, the Philippines and Singapore, Governments have put family support into legislation.

92. In the annex to its resolution 47/5 of 16 October 1992, the General Assembly decided to observe 1999 as the International Year of Older Persons. With the theme "Towards a society for all ages", the four facets for action are the situation of older persons, lifelong individual development, multigenerational relationships and the interplay of population

ageing and development. Moving towards a society for all ages requires policies and programmes that simultaneously strengthen individual lifelong development into late life, while fostering a society based on reciprocity, interdependence and equality. Of crucial importance to the success of this approach is mainstreaming a gender perspective in all policies and programmes. This requires making older women's concerns and experiences as well as older men's an integral dimension in designing, implementing, monitoring and evaluating policies and programmes, so that older women and men benefit equally. Empowering younger women is one of the most important means of securing the well-being of older women. Equity and equality in caregiving and income security are also important policy concerns, particularly at a time when many Governments are promoting more self-reliance in income security and greater family responsibility for caregiving.

IV. Internal migration

93. Migration is influenced by demographic, economic, social and life-cycle factors at both the individual and household levels. In recent decades, improvements in transportation and communications have facilitated increases in internal migration. Data limitations severely constrain the analysis of gender differences in internal migration, since few countries collect and publish data on internal migration by sex in their population censuses, and fewer still publish them also by age, education, marital status or labour-force status. In addition, only sample surveys can collect the detailed data needed to assess the determinants or consequences of migration, and few adequate surveys exist that focus on internal migration.

94. The most recent data from the 1990 round of censuses that include sex of the migrant are available for 13 developing countries. In Africa and Asia, less than half of internal migrants are female in seven of the eight countries with data, but in Latin America the majority are female in four of the five countries with data. Even so, the proportion female varies across the 13 countries only within a narrow range, from 43 to 56 per cent, though cultural and economic factors affecting migration by sex vary greatly from one country to another.

95. Data on migration flows differentiated according to place of origin and place of destination (urban or rural) are even more limited, and thus must be sought from earlier data sources, including the 1970 and 1980 rounds of censuses. Even then data are limited to one country in Africa (none in sub-Saharan Africa), six in Asia and two in Latin America. In Egypt, overall flows are virtually equal for men and women, but men slightly dominate rural-urban flows and women the smaller rural-rural flows. In Asia, females dominate overall flows in India owing to their 79 per cent share in the largest flow, rural-rural migration, which is associated with the custom of marriage migration. Males dominate the other three, smaller flows. Surprisingly, in neighbouring Pakistan, females are not in the majority even in rural-rural flows. In Thailand, the Philippines and generally in Latin America, men are predominant in rural-bound migration and women in movements to urban areas. In Malaysia and the Republic of Korea, the flows are virtually equal for men and women.

96. The increasing participation of women in the labour force in Latin America as well as in some Eastern and South-eastern Asian countries is closely linked to the increase in urban-ward migration of women, accompanying increasing urbanization. This may mean that migration flows in these countries, and in others where women's education and labour force participation approach those of men, will become more dominated in the future both by urban flows and by participation of women in those flows.

97. Data on the reasons people give for migrating are available from censuses and household surveys for five African countries, eight Asian countries and five Latin American countries, although some of the survey data are from small samples, often from only a single city. In the five African countries with the available data, male migrants cite economic reasons for having migrated far more than females do. More men also migrate for education, while the majority of women migrate for family reasons. Only in Ghana is there evidence of many women migrating for economic reasons. The situation is more mixed in the other regions. The eight Asian countries can be classified into distinct groups according to the proportion of women citing economic reasons: those with almost none citing economic reasons (India and Pakistan), those with small percentages (Malaysia and the Republic of Korea) and those with a third to a half (Bangladesh, Nepal, Indonesia, Thailand). For Thailand, data from a series of large surveys of migrants to Bangkok indicate that the proportions of males and especially of females migrating for economic reasons rose over time. Finally, in Latin America, differences by sex are smaller than in the other regions, and also involve larger numbers migrating for education. Economic motives are dominant for both sexes.

98. In all countries with available data, male migrants have higher levels of education than female migrants, though the differences are largest in Asia and smallest in Latin America. Similarly, data on migrants (prior to their migration) and non-migrants in the same areas of out-migration indicate migrant selectivity, that is to say, the fact that migrants are more educated than non-migrants in origin areas, which suggests that education is a factor influencing migration decisions.

99. While the literature on the determinants of migration is extensive, few studies look at men and women separately. An exception is a study based on the detailed 1988 Malaysia Family Life Survey II data which found that education was related to migration decisions for both sexes, but that being young and single was important only for women. Household composition was also relevant, as was land ownership, in respect of reducing the out-migration of both males and females. More recent theoretical and empirical work has begun to examine the effects of the area or context in which people live on their decisions to migrate. Studies on Ecuador and Thailand indicate that being married has no effect on sons but does reduce the out-migration of daughters (in Ecuador only), that a larger household size facilitates out-migration of both sexes and that better local rural employment opportunities reduce the out-migration of sons but not that of daughters.

100. With respect to the consequences of migration, studies should compare the situation of migrants with that of equivalent non-migrants remaining in places of origin. This has not yet been done, partly because it requires more costly data collection — that is to say, data from surveys in areas of both origin and destination of migrants. Instead, migrants are routinely compared with non-migrants in the place of destination, mainly urban areas, and this indicates migrant adjustment relative to natives rather than the consequences of migration. The data available are all of this nature, many comparing the economic status of migrants and non-migrants. Once again, few census publications or studies provide the necessary data for both sexes separately. Data on labour force participation rates for five countries show that, without exception, rates for both migrants and non-migrants are higher for males than for females, and those for migrants are higher than those for non-migrants. This is consistent with the expectation that migrants will have a lower "reservation wage", that is to say, that they will work for lower wages, since it is indeed for work that most do migrate.

101. Comparable data on the occupational distribution and economic sector of employment of migrant men and women are difficult to find. Studies based on surveys in Brazil and

Mexico indicate that male migrants are more likely than female migrants to be employed in higher-status occupations (women dominating household services and textiles). For both, however, there is significant diversification and improvement of occupations following migration. Data for Nepal and the Republic of Korea reveal similar gender differences, and suggest that men benefit more from migration than women. Data from studies of wage levels of migrants (in Mexico, Bangkok, Thailand and Shanghai, China) further suggest that the wide wage gap between men and women is not changed by migration, and that the gap is larger for migrants. More research is needed on this important issue.

V. International migration

102. At the global level, migrant women have been almost as numerous as migrant men in the stock of international migrants. The proportion of women in the total migrant stock remained almost unchanged at about 48 per cent from 1965 through 1990 (table 7). The male migrant population increased from 40 million (2.4 per cent of the world male population) to 63 million (2.4 per cent of the world male population) between 1965 and 1990, while the female migrant population had a comparable increase from 35 million (2.1 per cent of the world female population) to 57 million (2.2 per cent of the world female population) during the same period.

Table 7
Estimated male and female migrant stock and percentage female in total migrant stock, world and major areas, 1965 and 1990

	Number of migrants (millions)				*Percentage female in total migrant stock*	
	Male		*Female*			
Major area	*1965*	*1990*	*1965*	*1990*	*1965*	*1990*
World total	40.2	62.6	35.0	57.1	47	48
More developed regions	15.7	27.2	14.7	27.1	48	50
Less developing regions	24.5	35.4	20.3	30.1	45	46
Africa	4.6	8.4	3.4	7.2	42	46
Asia	16.9	23.5	14.5	19.5	46	45
Latin America and the Caribbean	3.2	3.9	2.7	3.6	45	48
Northern America	6.5	11.7	6.2	12.2	49	51
Europe and USSR (former)	7.6	12.8	7.1	12.3	48	49
Oceania	1.4	2.4	1.1	2.3	45	49

Source: Trends in Total Migrant Stock, Revision 4 (POP/IB/DB/96/1/Rev.4), database maintained by the Population Division, Department of Economic and Social Affairs of the United Nations Secretariat.

103. In the more developed regions, men and women constituted almost equal proportions of the migrant stock between 1965 and 1990. In contrast, women continued to constitute a lower proportion of the migrant stock in less developed regions, making up about 45-46 per cent of the total from 1965 through 1990. Countries with economies in transition, excluding the former Union of Soviet Socialist Republics (USSR), had the highest proportion of women in the migrant stock, 55 per cent of the total from 1975 onwards. Women migrants

slightly outnumbered male migrants also in Northern America, where they constituted 51 per cent of the nearly 24 million foreign-born persons living in the region in 1990.

104. In contrast, men predominate among migrants in Western Asia, where, in 1990, women accounted for only 40 per cent of the total migrant stock. In sub-Saharan Africa, males have been more numerous than females in the migrant stock since 1965. However, the proportionate share of female migrants increased noticeably from 41 per cent in 1960 to 47 per cent in 1990 as a result of the more rapid growth of the female migrant stock. In all other regions, the number of males in the migrant stock consistently exceeded the number of females, but generally by small margins: as of 1990, the proportion of women ranged between 45 and 50 per cent.

105. Data on migrant flows from the 1990s show, in many countries of Europe, a growing presence of women among migrants. Similarly, in Asia, although the volume of flows for female migrant workers still does not match the level of their male counterparts, participation of women in temporary labour migration has become increasingly more noticeable. Increasingly they are migrating as autonomous economic actors, rather than as dependants of their male family members.

106. Over the last few decades, flows of people in search of overseas employment have grown considerably. Recent estimates put the world total number of economically active foreigners at anywhere between 36 million and 42 million in the mid-1990s, with an even larger population (44 million to 55 million) residing abroad as their dependants.

107. There has been a rising number of women participating in migration for overseas employment on their own. Women migrating as contract workers tend to be concentrated in occupations of relatively low status that provide minimum prospects of socio-economic mobility in receiving societies. In particular, Asian female migrants are primarily involved in occupations such as domestic services, entertainment, nursing, restaurant and hotel services, and sales. Migrants from Latin America and the Caribbean are often engaged in domestic work. There is also a non-negligible number of women who have been involved in professional activities abroad. They originate not only from the main labour exporting countries, but also from economically affluent countries such as Japan, Malaysia and Singapore. The globalization of the economy and the expansion of international business have contributed worldwide to the increasing flows of highly skilled professionals, managers, consultants, personnel of international organizations and diplomats. With growing levels of women's education and skills, increasing participation of women in such migration is likely.

108. Much has been written about the vulnerable conditions of female migrant workers in receiving countries. Domestic service, which migrant women commonly choose throughout the world, is one of the most vulnerable occupations. Domestic workers are often subject to long working hours, low wages, few benefits and unpleasant working conditions. Moreover, sexual harassment by male employers is a common complaint. Trafficking of women (and children) for the sex industry, often associated with organized crime, is a growing global concern.

109. The evidence from migrant-receiving countries of the developed regions also suggests that migrant women, when compared with migrant men, are prone to be disadvantaged in respect of having access to the labour market of the receiving country. Migrants' free access to the local labour market is often restricted by the host country, especially when the migrants are admitted as dependants (a dependant status is the likely status of many women).

110. The constraints and disadvantages that migrant women face do not exclude positive gains from their labour-market experience in the country of destination. Labour migration

can contribute to the empowerment of women by opening new opportunities for them and providing them with their own income. Still, there is no consensus that migration either improves or diminishes the position of women relative to that of men.

111. When migrants cross national boundaries, sometimes family members move together, but more often one member of a family leaves for a destination earlier and the rest of the family members follow afterwards. Men are usually the first to move, because they are most often the breadwinner of the household and they find a job relatively easily at their destination. Women, in contrast, tend to have less autonomous mobility, as they are expected to assume caretaking roles for a family. Cultural restrictions of the country of origin also often prohibit women from migrating on their own. Consequently, more women are admitted into a country of destination as dependants of male migrants than in their own right.

112. In the United States, which receives the largest number of immigrants in the world, women made up 53 per cent of the 4.3 million migrants admitted during 1992-1996. Fifty-seven per cent of all immigrants were admitted under the category of family-sponsored immigrants, and women outnumbered men, constituting 57 per cent of this category.

113. Women also outnumber men in family migration to Western European countries. Those countries had admitted foreign workers, largely male and single, to ease their labour shortages in the 1950s and 1960s. Following the economic recession that resulted from the oil crisis of 1973, the Governments of the former labour-importing countries of Europe adopted measures to promote the return of migrants to their countries of origin and to facilitate family reunification for those workers who decided to stay. Consequently, the presence of women in foreign populations grew slowly during the 1970s and most of the 1980s. Although EU has affirmed the general principle of family reunification, more demanding conditions for the admission of foreigners for family reunification have gradually been imposed at the country level, often resulting in the reduction of the number of migrants entering those countries under family reunification.

114. Accurate statistical information is an important tool for formulating refugee assistance programmes. However, in many contexts, accurate statistics on persons in need of protection because they have been forced to leave their country of nationality are not readily available. Besides conceptual problems in regard to defining who a refugee is, practical obstacles hamper the counting of people in forced movement. Systematic efforts to compile data classified by sex are recent.

115. By the end of 1998, 79 countries could furnish the information. The distribution by sex is known for some 4.2 million refugees who were assisted by the Office of the United Nations High Commissioner for Refugees (UNHCR). They represent, however, only 37 per cent of the world refugee population, which was estimated at 11.5 million at the end of 1998. Therefore, the dearth of sex-specific refugee data makes any observations on male and female refugee migration provisional. The data available indicate that men and women constitute almost equal proportions in refugee populations. In most asylum countries, the proportion of females in the total refugee population falls in the range of 45-55 per cent.

116. At the regional level, the proportions of male and female refugees are almost even in the two regions hosting the largest number of refugees, namely, Africa and Asia. In Europe, female refugees moderately outnumber male refugees, making up 53 per cent of the total. In Latin America and the Caribbean, as well as in Oceania, refugee men slightly outnumber refugee women. In these regions, men constitute 53 per cent and 55 per cent, respectively, of the total refugee population.

117. While forced displacement affects both men and women, each has different needs for protection and assistance. Displaced women tend to bear a disproportionate share of the

hardship. Traditional disadvantages of women with respect to men are intensified in the chaos of emergency. During the course of displacement, and in refugee camps, violation of physical security is one of the most serious problems affecting women. Women may receive less food at distribution. The virtual lack of primary and reproductive health services also poses threats to their health.

118. Most migration-related policies and regulations are not gender-specific. The existing evidence shows, however, that because of their distinct roles and status, women and men are affected differently by regulations in force. The few gender-specific measures that exist address situations in which women's vulnerability is deemed a threat to their security. Such measures, which aim mostly at protecting them against sexual abuse and exploitation, have been developed during the last 10 years and concern mainly refugees and undocumented migrants.

119. Regarding labour migration, current admission policies do not include criteria that overtly discriminate against either men or women. However, since the entry status in a country confers specific migration-related rights, the stronger concentration of women in family reunification flows has influenced their status. In many labour-importing countries, residence permits of spouses and children are linked to that of the worker, and residence does not automatically grant employment rights. Gender-specific regulations on out-migration are scarce in sending countries in Africa and Latin America. In contrast, several labour-exporting countries in Asia have imposed restrictions on the out-migration of female workers. Concerns about exploitation abroad and about domestic shortages of women in specific professions have motivated such policies. The enforcement of restrictions varies greatly among countries, and provisions for exceptions often exist. Other factors limit their effectiveness. Welfare and protective measures are relatively new features in an institutional context set up to promote labour export.

120. Over the past 15 years, gender issues have gained increasing national and international attention in relation to refugees. First, gender-related persecution has been recognized by some countries — Australia, Canada, New Zealand, Norway, Switzerland, the United Kingdom and the United States, among others — as grounds for granting refugee status. Australia, Canada and the United States have introduced guidelines for the assessment of asylum requests involving gender. The Canadian *Guidelines on Women Refugee Claimants Fearing Gender-Related Persecution*, issued in 1993, list the specific forms of persecution encountered by women, which can assume five principal forms: harsh or inhuman treatment for the transgression of social norms; sexual violence; female genital mutilation and excision; coercive birth control; and domestic violence.

121. Second, the special needs of refugee women and their vulnerability to sexual and physical abuse have triggered a number of measures and programmes. During the 1990s, UNHCR issued guidelines for the protection of refugee women[17] and for prevention and response to sexual violence against refugees.[18] Other measures developed by UNHCR include the provision of economic facilities and training for women who are in long-term refugee situations and those who return home after exile. Gender-based protection faces obstacles. Most actions related to gender persecution pertain to the domestic domain, an area often regarded as being beyond the reach of international law. Denouncing and describing some forms of gender-based persecution in asylum interviews can be humiliating and difficult and substantiating a claim can prove to be harder in this type of refugee case than in others.

122. In the area of undocumented migration, trafficking is an issue of increasing political concern. Although there is no evidence to suggest that women are a majority among victims of trafficking, political and media attention has been focused on them as a particularly

vulnerable group. In the 1990s, Governments started to adopt legislation that criminalized trafficking activities, establishing penalties for illegal entry, transporting/harbouring and the provision of illegal employment, as well as document forgery and exploitation through sexual violence. Most countries in Northern and Western Europe and Northern America and an increasing number of countries in Central America and in Eastern Europe have adopted legislation on those issues. While such legislation initially focused on sanctioning and deporting the migrant, rather than on penalizing the perpetrator, some countries have lifted sanctions against victims of trafficking, particularly women, over the past five years. Innovative policy responses that encourage women to testify against traffickers have been developed recently in a few countries. The Netherlands was the first country to introduce a temporary residence permit for women victims of trafficking. Witness protection programmes exist in Belgium and are under discussion in the United States.

VI. Concluding remarks

123. The Programme of Action of the International Conference on Population and Development recognizes the fundamental relationship among population, gender and development. Chapter IV of the Programme of Action, for example, is devoted to the subject of gender equality, equity and empowerment of women. In addition, gender issues are given a prominent position throughout the Programme of Action. Gender concerns were also at the centre of discussion at the twenty-first special session of the General Assembly for the overall review and appraisal of the implementation of the Programme of Action. The importance of adopting a gender perspective in policy formulation and programme implementation was reiterated in the key actions for the further implementation of the Programme of Action adopted at the special session.

124. The world has experienced remarkable demographic change during the second half of the twentieth century. The pace of change has not been uniform across countries, however, nor has it been experienced uniformly by men and women. Although there have been vast overall improvements in the health and well-being of both men and women, the evidence illuminates the pervasive effects of gender and the links between inequalities in different domains and across the life cycle. In response to such evidence, Governments are paying increasing attention to the gender-specific implications of policies and programmes and have begun to address urgent issues, as reflected in the recommendations of the Programme of Action and the key actions for the further implementation of the Programme of Action adopted by the General Assembly.

125. Mortality, for example, has generally declined more rapidly for women than for men so that the differential in life expectancy in favour of women has increased, although in some countries girls are still disadvantaged in terms of survival in comparison with boys. While women continue to have universally higher life expectancy than men do, the increasing adoption of smoking by women has made tobacco-related mortality a threat to the female advantage.

126. Gender relations have also been shown to play a significant part in the course taken by the AIDS epidemic. Relative to men, women are at a disadvantage with respect both to their risk of acquiring the disease and to their dealing with its consequences in families and communities. The impact of AIDS has eroded part of the female advantage in life expectancy in those countries hardest-hit by the epidemic.

127. Also, as a result of declines in fertility, the amount of time women devote to childbearing and child-rearing has been substantially reduced, and this has facilitated their

participation in the labour force. Improvements in education, particularly of women, account for a significant proportion of observed declines in fertility and mortality. Higher education is also associated with later age at marriage and late transition to parenthood. Declining fertility is often accompanied by increased investment in children's schooling. However, in spite of unanimous international endorsement of education as a fundamental right, a catalyst of development and an important contributor to family well-being and enhanced health, access to schooling remains inadequate and gender gaps remain. Nevertheless, important progress has been made towards universal primary schooling, and sex differentials in school enrolment have narrowed.

128. Population ageing, the evolution to an older age structure as a result of declining fertility and mortality, has changed the balance in numbers of men and women. At ages 60 and older, for example, there are currently 1.2 women for each man; and at ages 80 and older, there are nearly twice as many women as men.

129. Among social scientists, demographers have traditionally analysed data separately for men and women. Gender-disaggregated data have been used to identify the relative position and role of men and women in social and demographic process across countries and over time. However, research that regards gender roles and relations as both determinants and consequences of demographic processes remains limited. The measurement of gender equality and equity also poses serious challenges for researchers. For example, measures that are universally applicable across different settings are few.

130. The emphasis given to gender issues at the International Conference on Population and Development has stimulated innovative research in this area. Researchers are increasingly paying attention to gender issues in the collection and analysis of demographic, social and economic data. This attention has highlighted the insights that may be gained from a gender perspective and is likely to further our understanding of the critically important relationships among population, gender and development.

Notes

[1] Economic and Social Council resolution 11 (II) of 21 June 1946.

[2] Economic and Social Council resolution 3 (III) of 3 October 1946.

[3] General Assembly resolution 217 A (III) of 10 December 1948.

[4] General Assembly resolution 2263 (XXII) of 7 November 1967.

[5] *Final Act of the International Conference on Human Rights, Teheran, 22 April to 13 May 1968* (United Nations publication, Sales No. E.68.XIV.2), chap. II.

[6] General Assembly resolution 34/180, annex.

[7] *Report of the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, Nairobi, 15-26 July 1985* (United Nations publication, Sales No. E.85.IV.10), chap. I, sect. A.

[8] *Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995* (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annex II.

[9] *Report of the United Nations World Population Conference, Bucharest, 19-30 August 1974* (United Nations publication, Sales No. E.75.XIII.3), chap. I.

[10] Ibid. sect. B.

[11] Ibid, sect. C.1 (c).

[12] *Report of the International Conference on Population, Mexico City, 6-14 August 1984* (United Nations publication, Sales No. E.84.XIII.16), chap. I, sect. B.III.B.

[13] Ibid. sect B.III.D.3.

[14] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

[15] General Assembly resolution S-21/2, annex.

[16] *World Population Prospects: The 1998 Revision*, vol. I, *Comprehensive Tables* (United Nations publication, Sales No. E.99.XIII.9), "Highlights of the *1998 Revision*".

[17] UNHCR, *Guidelines on the Protection of Refugee Women*.

[18] UNHCR, *Sexual Violence against Refugees: Guidelines on Prevention and Response* (Geneva, 1995).

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Follow-up actions to the recommendations of the International Conference on Population and Development

Monitoring of population programmes: population, gender and development

Report of the Secretary-General

Summary

The present report has been prepared in accordance with the new terms of reference of the Commission on Population and Development and its topic-oriented and prioritized multi-year work programme, which was endorsed by the Economic and Social Council in its resolution 1995/55. One of the topics for 1999 is gender, population and development.

This report is intended to give a broad overview of the range of activities that have been initiated towards implementation of the outcome of the International Conference on Population and Development in the area of gender, population and development. It presents the strategies and approaches that countries have adopted in response to the recommendations of the Programme of Action of the International Conference on Population and Development concerning gender in population and development. It also provides an analysis of the challenges and constraints encountered by countries in programme implementation and matters pertaining to resource mobilization within the area of gender, population and development.

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Introduction

1. The present report on the monitoring of population programmes has been prepared in accordance with the new terms of reference of the Commission on Population and Development and its topic-oriented and prioritized multi-year work programme, which was endorsed by the Economic and Social Council in its resolution 1995/55. One of the topics for 1999 is gender, population and development.

2. This report reviews progress with respect to population programmes and related development activities at the country level. It focuses on programme experiences and strategies in the area of gender, population and development initiated towards implementation of the outcome of the International Conference on Population and Development. It primarily addresses operational activities to promote gender equality and equity and the empowerment of women in population and development programmes.

3. Over the past decade, profound social, political and economic changes have taken place throughout the world. New objectives and goals on gender, population and development have been established that concern empowerment, equality and equity, human rights, male responsibility and participation, poverty, health, education, employment, violence, migration, the environment and the media.

4. These objectives have led to changes in the strategies used to reach the goals of equality and equity. They have signalled the unfolding of a political process that encourages the involvement of a spectrum of civil society and reflects the emergence of new partnerships. Promotion of gender equality, equity and empowerment of women has increasingly become important concerns for Governments, non-governmental organizations, civil society and, in many instances, the private sector.

5. The focus on gender, population and development has been underscored by the realization that women and men experience all aspects of development in different ways. Taking this into account increases the effectiveness of planning, policy formulation and programme implementation at every level. A gender-integrated approach to population and development aims to ensure that both men and women benefit equally from development efforts and enjoy equal access to, and control over, opportunities and resources. In turn, this supports accountability and participation in processes that impact on people's lives.

6. Gender as a perspective in development work recognizes and responds to the different roles, interests, needs and relations of men and women, which arise from their different responsibilities in society. Such roles and interests intersect with those based on class, ethnicity or age to override assumed homogeneity, which often results from focusing on women or men as a group. The preference for focusing on gender, as opposed to women or men, is also fuelled by widespread evidence showing that development benefits have been accruing in a substantially different manner to both men and women, with women gaining a fraction of what men are gaining. This perspective therefore aims to redress these imbalances.

I. Methodology

7. In preparation for this report, the United Nations Population Fund (UNFPA) analysed reviews of the various United Nations conferences conducted by United Nations organizations, and other documentary evidence as well as data from the 1998 UNFPA Field Inquiry on Progress in the Implementation of the ICPD Programme of Action (PoA) as part

of the International Conference on Population and Development plus five review process. A total of 114 developing countries and countries with economies in transition responded.[1]

8. The report focuses on efforts to effectively integrate gender into population and development programmes through strategies and initiatives to ensure access to quality sexual and reproductive health care and services, promotion of women's empowerment and protection of their reproductive rights, reduction of maternal mortality, protection of the girl child, increasing of women's participation in decision-making, and involvement of men in safeguarding their own as well as their partner's sexual and reproductive health. In addition, the report examines challenges and constraints that exist to date.

II. Gender, population and development in United Nations conferences

9. A series of international United Nations conferences have over the past two decades helped to create a shift from thinking of men or women as targets of development interventions, to a concern with gender relations, which may hinder or facilitate the realization of such interventions. The 1985 World Conference to Review and Appraise the Achievements of the United Nations Decade for Women,[2] held in Nairobi, analysed development efforts from a human rights, and specifically a women's rights, perspective. That conference demonstrated that obstacles to women's advancement have their roots in society and the economy, and that measures to overcome those obstacles must be based on the concepts of equality, integration, participation and cooperation. Subsequent global conferences, including the 1992 United Nations Conference on Environment and Development[3] held in Rio de Janeiro and the 1993 World Conference on Human Rights[4] held in Vienna were profoundly influenced by the Nairobi recommendations.

10. The Vienna Conference advanced the integration of a human rights approach to population and development, advocating for a strong commitment to women's rights, to safe motherhood, to the right to health, and to the availability of affordable quality family planning services and to timely access to information. These emerged as the key linkages between Vienna and Cairo. The adoption of the Programme of Action of the International Conference on Population and Development[5] in Cairo in 1994 established the essential linkage between gender concerns, on the one hand, and population and sustainable development, on the other. The International Conference on Population and Development further underscored the fact that the empowerment of women is an essential goal in itself, a position strongly reinforced at the Fourth World Conference on Women held in Beijing in 1995.[6]

11. The results of these conferences and the consensus they fostered ushered in a new paradigm in the formulation and implementation of population and development policies and programmes. Population issues are now seen in the broader context of reproductive health, human rights and sustainable development, for which the achievement of gender equality and equity and empowerment of women are essential. These goals are global and universal. Their implementation entails changes in attitudes and a focused commitment to internationally accepted norms and standards of gender equality, including the protection and promotion of the human rights of girls and women.

III. Promoting gender equality and empowerment of women

12. Various reviews indicate that considerable advances have been made, in both developed and developing countries, in promoting gender equality, in accordance with International Conference on Population and Development goals. The Field Inquiry carried out in view of the Conference plus five review showed that, in most countries, gender concerns have been integrated in population and development strategies by establishing and/or strengthening national institutional mechanisms dealing with population and/or gender concerns. Of the 114 countries that responded to the survey, 79 had revised their population policies and reported explicit new policy measures that reflected gender concerns in the overall development strategy.

A. Protecting rights and promoting women's empowerment

13. International recognition of the need to promote and protect women's right to reproductive and sexual health has continued to increase. Human rights treaty bodies have strengthened their commitment to the application of human rights standards to securing women's health, including their sexual and reproductive health. In January-February 1999, at its twentieth session, the Committee on the Elimination of Discrimination against Women (CEDAW) adopted general recommendation 24 on article 12 of the Convention on the Elimination of All Forms of Discrimination against Women — women and health,[7] expanding substantively on article 12 of the Convention[8] which focuses on women and health. At around the same time, the Commission on the Status of Women, at its forty-third session, recommended to the Economic and Social Council the approval of a draft resolution containing the Optional Protocol to the Convention,[9] which would give complainants due judicial process, for adoption by the General Assembly. The Council adopted the draft resolution (Council resolution 1999/13) and the Assembly, at its fifty-fourth session, noted the adoption of general recommendation 24 (Assembly resolution 54/137 of 17 December 1999) and adopted the Optional Protocol (Assembly resolution 54/4 of 6 October 1999). Both instruments are landmarks in protecting women's rights as human rights, including freedom from violence and coercion, and gender-based discrimination, and promoting their right to have control over, and decide freely and responsibly on matters related to, their own sexuality.

14. Propelled by the need to harmonize rights-based approaches within the United Nations system as well as among bilateral donors, the Inter-Agency Committee on Women and Gender Equality, established by the Administrative Committee on Coordination (ACC), jointly with the Division for the Advancement of Women of the United Nations Secretariat, organized a workshop in 1998 on a rights-based approach to the empowerment and advancement of women and gender equality. In 1999, another workshop for the same group was held, focusing on women's economic security issues. Both workshops reviewed various strategies to accelerate progress towards gender equality in different contexts, and assessed policy and operational implications, as well as collaborative approaches.

15. Countries have adopted a variety of national strategies to promote gender equality and equity through policy reform and legislative action which include: legislation to protect women's rights; family law modification; tougher legislation on violence against women; and establishment of women's affairs offices to protect women's rights and promote their empowerment. Courts in several jurisdictions have drawn on the Convention on the Elimination of All Forms of Discrimination against Women to assist in the interpretation

of domestic legal provisions. Countries have also intensified policy discussion and opened dialogue in new areas.

16. Nearly half of all countries surveyed reviewed their policies in light of a new understanding of the role of population in development. More than one third have recently updated their population policies or have integrated factors relating to quality of health care, gender equality and equity, and improvement of information systems, into long-term development plans. Furthermore, two thirds of all countries have introduced policy or legislative measures in areas such as inheritance, property rights and employment, and protection from gender-based violence.

17. Some of the most important initiatives Governments have taken involve the strengthening of national laws, policies and mechanisms promoting human rights, including reproductive rights. This has entailed the development of comprehensive women's health policies that assist countries in moving from a target-based family planning approach to a client-centred approach where a range of services, including expanded choices of contraceptive methods, are offered. Countries are also lifting regulations and policies, for example, on marital status and spousal permission, that limit wider access to reproductive health and family planning services.

18. Developed countries have also had to make new adjustments. For example, social security systems have been based on the traditional concept of a woman as dependent spouse. However, a number of countries have taken steps to adapt their social security legislation to the new realities created by women's participation in paid employment.[10] This recognizes that women in paid employment have acquired independent rights to social security coverage.

19. A major obstacle to the realization of women's rights is their inability to own and control access to land. Although women's right to land is a critical factor for food production, they continue to be largely prohibited by sociocultural norms and practices from owning and controlling access to land. This impacts negatively on their access to other natural resources, such as water, fuelwood, fish and forest products, which are crucial for food security, on income and, ultimately, on health.

20. While many national plans highlight efforts to achieve de facto equality of women, they also emphasize the continuing need for legislative and administrative reform to eliminate the inequality and discrimination that continue to exist.

B. Promoting women's participation in decision-making

21. Both the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action[11] underscored that the empowerment and autonomy of women and the improvement of their political, social, economic and health status are highly important ends in themselves. The promotion of women's participation in decision-making is an important strategy towards this end. In this regard, many countries have established mechanisms for women's equal participation and equitable representation at all levels of the political process and public life. These include minimum quotas for women in electoral bodies and public institutions. Governments are involving women-related institutions, primarily non-governmental organizations, in government policy and oversight groups.

22. However women continue to be grossly under-represented in positions of power and decision-making, because of obstacles such as poverty, illiteracy, limited access to

education, inadequate financial resources, a patriarchal mentality and the dual burden of women's domestic tasks and occupational obligations.

C. Globalization and its impact on women's health

23. Past development policies and economic strategies have contributed to an improvement in the health status of both men and women, particularly in those instances where there has been a simultaneous emphasis on social policies. These have invariably improved quality-of-life indicators, including life expectancy, and reduced infant, child and maternal mortality rates. Most countries have witnessed progressive development of health infrastructure, including secondary and tertiary care, as well as a wide primary health care system aimed at bringing health services to the community level.

24. More recent developments, however, have undermined some of these gains. The impact of certain trends in the global and national economies poses significant threats to attaining and sustaining health in general, and women's health in particular. Among the most important of these trends are privatization and the increasing role of the market mechanism; global recession; structural adjustment policies; and global trade.[12] In each case, women's health has borne the brunt owing to gender roles that restrict their access to income, thereby making them unable to exercise leverage in accessing health under these new circumstances.

25. For people in many developing countries, privatization of the health sector has been associated with lessening access to health services, as the cost of services has risen. At the same time, privatization in some instances has lowered the quality of health services, as the role of the State in establishing norms and standards and enforcing supervisory mechanisms has weakened. The private sector's capacity to deliver health services equitably has, in many cases, been overestimated, and the impact on women has been considerably different from that on men. In many countries in Asia and Africa, the provision of health care, especially reproductive health care, has been shifted out of the hospitals and other health-care centres, and on to the shoulders of women and, increasingly, young girls. This is particularly the case for long-term care that families can no longer afford to purchase.

26. Global recession has had a profound impact in some parts of the world. In Africa, for example, many countries have been left with a heavy and ever-increasing debt burden. The servicing of this debt drains financial resources that could otherwise be invested in health services and infrastructure. The results are evident. At the community level, poverty is on the rise, and a greater proportion of families are unable to meet their basic needs. In the health sector, hospitals and clinics are crowded and basic drugs are missing. Health personnel are overworked and underpaid, and lack training and necessary skills. Many seek alternative employment, thereby further depriving the sector of needed personnel. Consequently, health indicators, such as maternal mortality rates, have stagnated and, in a few instances, taken a downward trend.

D. Improving access to, and availability of, reproductive health services

27. The integration of family planning and maternal and child health under a common institutional umbrella has been the most common change in respect of providing effective health-care delivery services. Gender-sensitive reproductive health services that ensure universal access to quality health care have become priorities in health sector reform and sector-wide approaches.

28. Many countries are testing ways of integrating reproductive health services, while others are establishing linkages among the components of reproductive health, particularly family planning, maternal and child health and sexually transmitted diseases/human immunodeficiency virus/acquired immunodeficiency syndrome (STDs/HIV/AIDS) services, through development of referral systems. This has contributed to improved access to services and to better-trained service providers. As a result, essential health services packages are becoming increasingly available at delivery points, and better referral systems are ensuring increased availability of, *inter alia*, STD treatment and emergency obstetric care.

29. Health ministries and family planning agencies in developing countries are focusing increasingly on the quality of the services they provide. Many are seeking new strategies to improve counselling so as to respond to the needs of clients. Programmes are increasingly offering a wider choice of methods to take into account users' widely varying reproductive choices, health status, age and life circumstances. Social or subsidized marketing strategies have been successful in increasing access to contraceptives, including male and female condoms. Advocacy campaigns targeting men have been particularly helpful in increasing the use of condoms and vasectomy.

30. Of the 114 countries that responded to the Field Inquiry, 36 stated that they were offering all the components of reproductive health as stated in the Programme of Action of the International Conference on Population and Development. In the last five years, 54 countries have taken some measures to add new components to their existing reproductive health programmes. Progress was most evident in Asia, where 45 per cent of the countries have taken some measures, followed by Africa, with 44 per cent of countries having done so.

31. The most common measures taken by countries in adding new components to reproductive health programmes encompass the provision of services for the prevention and treatment of STDs, including HIV/AIDS. Forty-five countries reported adding services for the prevention and treatment of infertility and the treatment of reproductive tract infections, and providing safe delivery and post-natal care including prenatal care (table 1).

32. The Field Inquiry results also suggested that more progress had been made in improving universal access to, than in the expanding of, reproductive health services. Among the developing countries, a total of 59 countries (76 per cent) are taking measures to improve universal access. More than half of the countries in Africa, Asia and Latin America and the Caribbean reported progress in improving universal access to reproductive health care services.

33. The most common measures taken by countries to improve access to reproductive health services were (a) increased training of service providers; (b) expanding and/or constructing more health service delivery points; and (c) allocating more equipment and resources and/or increased provision of equipment (table 2).

Table 1.
Measures taken by countries to add new components of reproductive health

Measures	*Countries*
Prevention and treatment of STDs/HIV/AIDS	Burundi, Democratic People's Republic of Korea, Dominican Republic, Kenya, Latvia, Lesotho, Marshall Islands, Mexico, Micronesia, Niger, Pakistan, Paraguay, Poland, Tajikistan, Tuvalu, United Republic of Tanzania, Uruguay
Prevention and treatment of infertility	Algeria, Bangladesh, Bhutan, Bolivia, China, El Salvador, Honduras, Islamic Republic of Iran, Kenya, Madagascar, Mali, Mongolia, Niger, Nigeria, Philippines, Senegal, Yemen
Provision of safe delivery and post-natal care	Azerbaijan, Botswana, Burundi, Costa Rica, Democratic People's Republic of Korea, Dominican Republic, Ecuador, Gambia, Guinea-Bissau, India, Islamic Republic of Iran, Jordan, Nigeria, Latvia, Maldives, Marshall Islands, Mexico, Micronesia, Nepal, Pakistan, Poland, Paraguay, Tajikistan, Tuvalu, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu
Provision of prenatal care	Botswana, Burundi, Costa Rica, Dominican Republic, Ecuador, Gambia, Guinea-Bissau, India, Islamic Republic of Iran, Jordan, Lesotho, Maldives, Mali, Marshall Islands, Mexico, Micronesia, Mozambique, Nepal, Niger, Nigeria, Pakistan, Paraguay, Poland, Tajikistan, Tuvalu, United Republic of Tanzania, Uruguay, Vanuatu

Table 2.
Measures taken by countries to improve universal access to reproductive health

Measures	*Countries*
Training of service providers	Azerbaijan, Bhutan, Cambodia, Central African Republic, Cook Islands, Ghana, El Salvador, Honduras, Islamic Republic of Iran, Jordan, Kenya, Marshall Islands, Micronesia, Papua New Guinea, Samoa, Swaziland, Turkey, Uganda, Uzbekistan
Expansion/construction of more health centres	Albania, Bangladesh, Belize, Burundi, Cambodia, Central African Republic, Cuba, Dominican Republic, El Salvador, Ethiopia, Ghana, Guinea, Honduras, India, Islamic Republic of Iran, Jordan, Kenya, Latvia, Lesotho, Madagascar, Marshall Islands, Micronesia, Mongolia, Morocco, Nepal, Pakistan, Papua New Guinea, Philippines, Samoa, Tunisia, Turkey, Uganda, Ukraine, Zambia, Zimbabwe
Allocating more resources and/or increased provision of equipment	Azerbaijan, Bolivia, Central African Republic, Dominican Republic, Egypt, Ghana, Madagascar, Mali, Micronesia, Nigeria, Papua New Guinea, Peru, Syrian Arab Republic, South Africa

E. Reducing maternal mortality

34. The Programme of Action of the International Conference on Population and Development calls for the reduction of the 1990 level of maternal mortality by half by the year 2000 and by a further one half by 2015 (para. 8.21). Towards this end, some progress is evident. Maternal health has improved in a number of developing countries as a result of the expansion of midwifery skills, the existence of a general health infrastructure and the accessibility of health care. That safe motherhood has been identified as being both a development issue and a human rights imperative has resulted in a greater awareness of the

issues of maternal mortality and morbidity. Most countries are strengthening efforts to prevent unwanted pregnancies, whiles others are working more systematically to reduce the health impact of unsafe abortion.

35. A large number of countries now allow abortion in order to save the lives of pregnant women. Only a few, however, have made progress in ensuring that, in all circumstances where it is not against the law, there are sufficiently trained and skilled personnel and facilities to ensure that the procedure is safe and accessible. Services to treat women suffering from life- and health-threatening complications of unsafe abortion are often not available.

36. In recent years, substantial declines in levels of abortion have been documented in Central and Eastern Europe/newly independent States and in the Central Asian republics, as a result of increased availability and use of modern contraceptives. Some progress has been made in training health-care providers and equipping hospitals in the management of complications arising from abortion, and several developing countries have developed special approaches to improve post-abortion services and care.

37. Despite these achievements, overall progress in reducing maternal mortality has been slow. The major factors contributing to high levels of maternal mortality and morbidity in developing countries still persist. These include the low status of women, their lifelong poor nutritional status and high levels of anaemia. Reducing maternal mortality is constrained not so much by lack of technology as by insufficient political commitment and resources, and by the failure to prioritize effective interventions.

F. The acquired immunodeficiency syndrome (AIDS) pandemic

38. The most recent Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) (UNAIDS)/World Health Organization (WHO) report, of December 1998, estimates that more than 95 per cent of all HIV-infected people live in developing countries. Globally, 33.4 million people are living with HIV infection or AIDS. Of these, 32.2 million are adults and 1.2 million are children under age 15. Almost 3 million young people aged 15-24 were infected with HIV in 1998. Women now account for the highest proportional increase in new infections, as they constituted 43 per cent of newly infected adults in 1998, compared with 41 per cent just one year earlier. Infection rates among married women with only one partner are also very high in developing countries.

39. Sub-Sahara Africa has been particularly hard hit. Although it has only 10 per cent of the world's population, 70 per cent of all new infections since 1998 have occurred in that region, and now more than two thirds of people living with AIDS are in the region. Of the 2.5 million deaths from AIDS in 1998, 2 million occurred in Sub-Sahara Africa. Ninety-five per cent of all AIDS orphans in this region have lost their mother or both parents to AIDS. In Africa, HIV-positive women now outnumber infected men by 2 million.[13]

40. The gender dimensions of HIV/AIDS, which give rise to these trends, pose a special threat to women. The UNAIDS/WHO report notes that women are generally at greater risk of HIV infection than men. Women have a higher biologically determined susceptibility to STDs/HIV. Their culturally determined roles leave them with little control over their own sexuality and low, if any, negotiating power regarding sexual practices. New studies also indicate a clear linkage between HIV transmission and acts of sexual violence, affecting, in particular, women in the commercial sex industry.[14]

41. Another aspect of women's vulnerability to HIV/AIDS is linked to age and economic status. AIDS is commonest among young and poor women. This is the section of the population that often lacks basic education, decent housing, adequate food and access to quality medical care. While the drugs used to treat HIV/AIDS are unavailable to most people, they are even farther out of the reach of women. They often lack the means to seek medical help or are unable to do so because their unemployment status precludes them from participating in medical insurance schemes through which such assistance is usually given. Adolescent girls are particularly vulnerable — studies in several countries have found that African girls aged 15-19 are five to six times more likely to be HIV-positive than boys the same age.[15]

42. At present rates of infection, it is estimated that maternal deaths due to AIDS in Africa, Asia and Latin America will leave nearly 42 million children orphans by the year 2010. Mother-to-child transmission of HIV affects approximately 300,000 newborns each year, most of them from developing nations.

43. The scope of the pandemic and its gender dimensions create the need to develop multiple strategies to address its complexities. This includes analysing the effects of the health sector reforms that have been put in place in many developing countries at a time when imperatives for public investment in health are increasing. This state of affairs has impeded the capacity of health systems to respond effectively to the AIDS pandemic, especially in the worst-hit countries in Africa. As a result, many health systems are on the verge of collapse, and significant gains in reducing maternal and infant mortality have been reversed.

G. Addressing the needs of adolescents

44. Adolescent reproductive health is now clearly part of the public-health agenda in the majority of countries. A large number of countries have adopted policies, standards and mechanisms to address the needs of adolescents. They have incorporated adolescent reproductive health components into youth programmes and national health plans, or have established youth offices within ministries. Progress has been achieved in providing information and services for adolescents. Early marriage and some harmful practices against girls are on the decline. The need to listen to and consult young people themselves is being increasingly regarded as a vital input to the design, planning and implementation of programmes offering information and services to adolescents.

45. A total of 91 countries that responded to the Field Inquiry took action to improve adolescent reproductive health. Countries in the Latin American and Caribbean region have shown the greatest progress in meeting adolescent reproductive health needs, followed by those in Africa. Of the countries that have taken measures to address these needs, several have provided outreach efforts/advocacy and school-based programmes; developed youth-related policies; and established new institutions for providing reproductive health services to adolescents (table 3).

46. Despite considerable progress in collaborative work between non-governmental organizations, the private sector and Governments, particularly in Africa, adolescents continue to be one of the most under-served groups, especially considering their large numbers. As a result, unplanned parenthood for both girls and boys often curtail their potentialities very early in their lives, and uninformed decision-making about sexual behaviour exposes them to STDs including HIV/AIDS. Greater political commitment that

demonstrates a willingness to devise acceptable and effective strategies is therefore imperative.

Table 3.
Measures taken by countries to address the needs of adolescent reproductive health

Measures	*Countries*
Outreach efforts/advocacy	Albania, Azerbaijan, Barbados, Bhutan, Bolivia, Cameroon, Cape Verde, Comoros, Costa Rica, Cuba, Ecuador, El Salvador, Ethiopia, Haiti, Kenya, Lao People's Democratic Republic, Madagascar, Malawi, Maldives, Mauritius, Mexico, Micronesia, Mongolia, Morocco, Mozambique, Namibia, Nepal, Papua New Guinea, Saint Lucia, Seychelles, Sierra Leone, Sri Lanka, Syrian Arab Republic, Trinidad and Tobago, Turkey, United Republic of Tanzania, Uruguay, Uzbekistan, Venezuela, Viet Nam, Zambia
School-based programmes	Azerbaijan, Bhutan, Cape Verde, Central African Republic, Comoros, Côte d'Ivoire, Democratic People's Republic of Korea, Ecuador, Egypt, Estonia, Fiji, Gambia, Haiti, Jordan, Kiribati, Lesotho, Madagascar, Mali, Micronesia, Mongolia, Morocco, Panama, Papua New Guinea, Peru, Poland, Romania, Russian Federation, South Africa, Turkey, Turkmenistan, Uzbekistan, Viet Nam
Youth-related policies	Bangladesh, Bolivia, Botswana, Cameroon, Costa Rica, Cote d'Ivoire, Ecuador, El Salvador, Estonia, Honduras, Lesotho, Malawi, Mali, Mexico, Morocco, Nepal, Niger, Nigeria, Panama, Paraguay, Peru, Poland, Romania, Sierra Leone, South Africa, Uganda, United Republic of Tanzania, Viet Nam, Zambia
New institutions	Albania, Bhutan, Burkina Faso, Cape Verde, Costa Rica, Dominican Republic, Ecuador, Fiji, Ghana, Kazakhstan, Mongolia, Mozambique, Nicaragua, Sri Lanka, Turkmenistan
Youth counselling	Angola, Cook Islands, Costa Rica, Côte d'Ivoire, Cuba, Egypt, Estonia, Gambia, Honduras, Madagascar, Mali, Mexico, Micronesia, Mongolia, Morocco, Nicaragua, Tonga, Uruguay
Non-governmental organization participation	Azerbaijan, Barbados, Bolivia, Botswana, Cape Verde, Comoros, Costa Rica, Ecuador, Egypt, Estonia, Ethiopia, Fiji, Gambia, Ghana, India Jamaica, Kenya, Maldives, Mali, Marshall Islands, Nepal, Nicaragua, Panama, Romania, Senegal, Sierra Leone, Syrian Arab Republic, Tonga, Turkey, Tuvalu, Uzbekistan, Vanuatu, Venezuela, Zambia

H. Elimination of violence against women

47. Violence against women is a serious obstacle to the achievement of women's human rights. Governments in collaboration with the United Nations system, international and local non-governmental organizations have become active partners in promoting zero-tolerance of violence against women. The strategies adopted have varied widely. The Convention on the Elimination of All Forms of Discrimination against Women is increasingly being used as a monitoring instrument on, *inter alia*, gender violence. Other related United Nations institutional mechanisms for protecting human rights offer powerful support for legal, political and social actions to protect women from violence, and countries are beginning to use them effectively at the national level.

48. As a result, gender-based violence, once taboo, is now being openly acknowledged. Laws have been enacted in a number of countries to protect women from violence, and codes of family law have been revised to include issues of domestic violence. Other strategies adopted include establishment of family counselling and support centres, telephone hotlines to report incidence of domestic violence, programmes to train police to deal with such violence, training about sexual harassment especially in work environments, and development of financial schemes for rural women to enhance their economic options.

49. To ensure the success of these strategies implementers are establishing linkages among government agencies, law enforcement bodies, non-governmental organizations, and women's groups. Non-governmental organizations, for example, have been effective in creating centres for victims of rape, incest and other forms of violence, while Governments are strengthening their data-collection systems on marriage and divorce and training judges and religious leaders to develop and use monitoring mechanisms to track violence against women. However, given the pervasiveness of violence against women, these efforts need to be reinforced considerably.

I. Taking action against harmful practices

50. Abolishing harmful practices requires a long-term commitment. Interventions need to be focused, specific and based on a thorough understanding of the cultural environment. Harmful practices constitute a form of gender-based violence and are now explicitly addressed in the Convention on the Elimination of All Forms of Discrimination against Women.

51. Progress has been made in outlawing harmful practices that compromise the well-being of women and girls. Nine African countries — Burkina Faso, the Central African Republic, Côte d'Ivoire, Djibouti, Ghana, Guinea, Senegal, Togo and the United Republic of Tanzania — have taken steps towards criminalizing the practice of female genital mutilation. The penalties range from a minimum of six months to a maximum of life in prison. In Egypt, the Ministry of Health issued a decree declaring female genital mutilation unlawful.

52. Countries have thus demonstrated that successful initiatives can be undertaken to eliminate harmful practices without compromising sound cultural values. Various country-specific strategies are used. These include providing new information and skills supportive of women's health to adherents of harmful practices; undertaking campaigns on women's rights so as to sensitize lawmakers and the public alike on the health dangers and the human rights violations posed by some cultural practices; establishing monitoring mechanisms, entailing research and advocacy, to document and disseminate information on the prevalence and nature of harmful practices; and using intersectoral approaches that involve community leaders, church organizations, parent-teacher associations and the government to eradicate such practices.

53. Countries have recognized the need to adopt integrated approaches that address the social, cultural and economic context within which harmful practices thrive. Governments are therefore supporting the role of family members, especially parents and other legal guardians, in strengthening the self-image, self-esteem and status of young girls and protecting their health and well-being.

54. Nonetheless, harmful practices continue to persist and endanger the health and lives of large numbers of women and girls. Honour killings, widow-cleansing rites, forced marriages and bride burning are still common. Reasons for their persistence include the

absence of laws to combat them, gender biases in enforcing existing laws, and lack of autonomy for women.

J. Advocacy for the education of the girl child

55. Educating girls is a key factor in building their self-esteem and confidence. Moreover, evidence continues to accumulate that girls' education is one of the strongest correlates of women's reproductive health status. Many studies demonstrate that education of girls leads to fewer and healthier children, informed health-seeking behaviour for self and family, and timely recourse to health care.[16]

56. The Field Inquiry results show that 57 countries (50 per cent) considered their level of access to primary education of the girl child already adequate. Sixty-one per cent and 59 per cent of African and Asian countries, respectively, reported taking some measures to improve access to primary education, particularly for the girl child.

57. Governments are moving closer to achieving universal access to primary education. Developing countries have now placed greater emphasis on providing free education or scholarships, increasing the number and location of schools, and revising curricula to make them more gender-sensitive. Some have introduced legal measures to support the right of girls to education. These initiatives have contributed to an increase in the primary school enrolment ratios of girls in numerous countries. In most regions of the world, the female primary enrolment ratio as a proportion of male enrolment now exceeds 80 per cent.

58. However, universal access to basic education and the closing of the gender gap in education are yet to be achieved, especially in sub-Saharan Africa and South Asia. Children living in conditions of poverty, particularly girls, have the lowest educational attainment rates. School drop-out rates are high at all levels, particularly during the transition between primary and secondary school. Low-income families are often unable to meet the costs of school uniforms, fees, books and transport. Retention rates, especially among girls, are often poor. Moreover, high pupil-teacher ratios, inadequate or gender-inappropriate curricula, insufficiently trained teachers and inadequately equipped schools all lower the quality of education in these regions. Declining investments in educational infrastructure as a function of poor economies are also a major contributing factor.

K. Enhancing men's roles in the family and in reproductive health

59. In the last few years, more attention has been focused on male involvement in sexual and reproductive health, through sex education, counselling and health outreach services. This has been driven by the premise that such involvement leads to healthier reproductive health outcomes for both men and their partners. A large majority of countries that responded to the Field Survey have acted to increase men's responsibility for their sexual and reproductive behaviour and their social and family roles, through measures such as employment legislation and child-support laws.

60. Among countries that have special reproductive health activities for men, advocacy campaigns have been the most common. These have used approaches that address the effects of sociocultural attitudes and practices, including gender-based violence, on the sexual health and reproductive rights of women and girls. Countries are also increasingly expanding their family laws to respond to the needs of men with respect to single fatherhood, child custody and adoption and related issues.

61. According to the Field Inquiry results, 37 countries have taken measures to promote male involvement in sexual and reproductive health (table 4).

Table 4.
Measures taken by selected countries to promote male involvement in sexual and reproductive health

Measures taken	*Countries*
Education; information, education and communication (IEC); and advocacy activities, including multimedia campaigns	Angola, Barbados, Belize, Botswana, Brazil, Burkina Faso, Burundi, Cape Verde, Central African Republic, Comoros, Democratic People's Republic of Korea, Democratic Republic of the Congo, Dominican Republic, Egypt, Ethiopia, Islamic Republic of Iran, Jamaica, Jordan, Fiji, Lao People's Democratic Republic, Malawi, Maldives, Mali, Marshall Islands, Mauritania, Mexico, Micronesia, Mozambique, Nepal, Pakistan, Papua New Guinea, Paraguay, Peru, Philippines, Saint Lucia, Samoa, Seychelles, Swaziland, Syrian Arab Republic, Thailand, Trinidad and Tobago, Tunisia, Turkey, United Republic of Tanzania, Uruguay, Vanuatu, Venezuela, Viet Nam, Yemen, Zambia Zimbabwe
Family law modification, including revised and expanded laws on child support and paternity	Belize, Bhutan, Botswana, Brazil, Cape Verde, Colombia, Costa Rica, Dominican Republic, El Salvador, Ghana, Guinea, Jamaica, Jordan, Marshall Islands, Mongolia, Mozambique, Nicaragua, Niger, Peru, Poland, Romania, Saint Lucia, South Africa, Viet Nam, Zambia
Promotion of male contraceptive methods, including condom distribution and male vasectomy	Bhutan, Botswana, China, Democratic People's Republic of Korea, Fiji, India, Kiribati, Peru, Samoa, Viet Nam

62. Some countries are conducting research and surveys to understand the needs in respect of, and obstacles to, male participation in reproductive health.[17] Other initiatives include: national policies and plans to promote male involvement; activities that involve men in community-based distribution and promotion of condoms; and advocacy workshops conducted at central and provincial levels.

L. Responding to emergency situations

63. The growing need for reproductive health care in emergency situations has been clearly acknowledged, and several United Nations organizations and international non-governmental organizations are now working to meet these needs. Ensuring the reproductive health of refugees and displaced persons, and protecting refugee women from sexual violence, are priority concerns wherever conflict or natural disaster takes place.

64. In Africa's Great Lakes region, there are programmes to train staff and provide equipment and supplies to women in emergency situations in order to address their needs in: family planning, including contraception; assisted childbirth; complications of unsafe abortion; sexual violence and rape, including post-coital emergency contraception; and prevention of STDs, including HIV/AIDS.

65. United Nations organizations in partnership with international non-governmental organizations have provided emergency reproductive health assistance to thousands of people fleeing the conflict in Kosovo, as well as to camps in Albania and East Timor. An

investigation of sexual violence against Kosovar women uncovered accounts of abduction, rape and torture. The United Nations and its partners are providing training for counsellors in offering support to refugees who have been subjected to sexual violence. Emergency assistance has also been provided to the victims of earthquakes in several developing countries.

66. In Asia, United Nations organizations in collaboration with national Governments have provided, *inter alia*, dietary supplements, as an emergency measure, to populations most at risk. International institutions are strengthening the capacity of local branches of government and civil societies, including non-governmental organizations, to respond to emergency situations. This type of capacity-building is likely to be strategic for many other countries.

67. Although reproductive health services are provided in emergencies, these efforts are often hampered by a lack of personnel knowledgeable in reproductive health or skilled in the management of reproductive health services.

IV. Gender concerns in population and development programmes: challenges and constraints

A. Trafficking in women and girls

68. Sexual exploitation and trafficking in children are now growing as a global problem. Each year, it is estimated that more than 2 million girls between ages 5 and 15 are introduced to the commercial sex market.[18] Commercialization of sex is closely tied to poverty in developing countries. Rural poverty, high unemployment and expanding inequalities between the rich and poor are factors that underpin this trade. In some developing countries, young women from poor rural families are taken to cities where a thriving sex industry caters to a wealthy local and tourist clientele. The sex trade, including pornography, has also become a high-tech trade supported by, *inter alia*, the Internet and increasingly linked to organized crime.

69. Women working in the commercial sex industry are much more exposed to STD/HIV infection than most other women. They suffer disproportionately from reproductive tract infections. In some studies, up to 80 per cent have been found to be HIV-positive. Studies of patterns of HIV infection in some countries show a clear linkage between commercial sex and HIV transmission. HIV infection also spreads fastest along trucking routes, where truck drivers have frequent recourse to commercial and unprotected sex.

B. Sex selection

70. According to UNFPA's *The State of World Population, 1997*, at least 60 million girls who would otherwise be expected to be alive are "missing" from various populations as a result of sex-selective abortions or neglect.[19] Through the use of modern technology, parents can determine the sex of the foetus and subsequently choose to abort the foetus when it would turn out to be a girl: over 90 per cent of foetuses aborted are girls.

71. Legal measures are just one aspect of overcoming gender discrimination. Public education, action to increase the status of women and girls, appropriate legislative frameworks, and continued monitoring and enforcement of prohibitions are other important steps to stop such practices and enhance the value attached to girl children.[20]

C. Feminization of poverty

72. Despite the progress made in improving the status of women in many countries, a larger proportion of women than ever before now live in poverty. Whereas in the developed countries women have made considerable progress, indicated by their increased life expectancy, literacy rates, educational attainment and political participation, the situation in developing countries is different. The absolute number of women living in poverty has grown and certain human development indicators suggest that poverty has increasingly become a female problem.[21]

73. This situation is a function of the intersection between macrolevel factors such as the persistence of debt, global trade and global recession, which hold particular consequences for women, and microlevel crises within the family itself. Owing to the death of usually older husbands, migration of working spouses, and high rates of desertion and divorce, many women now maintain households virtually on their own. As a result, in parts of Africa, a woman heads one out of every three households. Women now bear a disproportionate share of poverty worldwide and shoulder an unequal burden of coping with poverty at the household level.[22] These two interrelated facts reinforce the vulnerability of women, including their inability to exercise their right to health and to development in general.

74. Attacking poverty by providing economic opportunities improves reproductive health, and realizing sexual and reproductive rights will help to end poverty. In this regard, the poor are multiply disadvantaged. Lacking political influence and social visibility, they are underserved by public services and cannot afford private services to meet their fundamental needs. Their days are often caught up in a struggle for survival. Their basic social and economic rights, including the right to reproductive and sexual health, are often restricted, and they lack information and knowledge regarding these rights.

75. In societies where tradition insists on the social isolation of women, self-employment programmes can have considerable impact simply by involving women in informal social interaction with other women, including those who practice family planning. Along with increased availability of information and access to credit, the result can be changes in social norms concerning fertility and contraception. Experiences of this kind to date confirm that the benefits of individual control over reproductive life and those of individual control over economic life reinforce each other.[23] Improving livelihoods, while also ensuring access to reproductive health services and information, enhances women's self-esteem, their confidence, their participation in political and community life, their decision-making power and their position in the family. They benefit, their families benefit and their communities prosper.

D. Constraints on implementation

76. According to the UNFPA Field Inquiry, the most frequent constraints affecting policy implementation in population and development were as follows: (a) insufficient institutional commitment; (b) lack of financial resources; and (c) lack of institutional capacity, including trained/qualified staff, lack of awareness and understanding of the issues, lack of data, and insufficient coordination among institutions and ministries.

77. Major constraints on the development of sexual and reproductive health policies, and related legislation, exist in many countries. Adverse economic conditions may limit access to reproductive health, sexual health and family planning services. Many social, cultural and religious attitudes and beliefs still put women's childbearing functions before other roles

and restrict women's decision-making in the private and public domain. Restrictive attitudes also limit women's economic and political participation as well as their access to information and knowledge, and exclude their views as important stakeholders in policy formulation, planning and implementation.

1. Persistence of negative cultural attitudes and practices

78. Traditional practices dangerous to the health of women and the girl child have been denounced at several global conferences, including the World Conference on Human Rights, the International Conference on Population and Development and the Fourth World Conference on Women. Governments are increasingly urged to take steps to combat harmful traditional or customary practices. Such practices are sustained by people's attitudes towards women. They perpetuate gender gaps, hinder efforts to empower women, thwart strategies to integrate a human rights perspective and nullify legal and related interventions to promote gender equality.

79. In order to meet commitments made in various international and national forums, many countries identify legislative and policy actions as being imperative. Similarly, they emphasize the need for increased advocacy and information, education and communication (IEC) campaigns to combat harmful practices. While a large number of countries have passed laws, made institutional changes and formulated policies that promote gender equality, the biggest challenge encompasses the implementation of these measures and the assurance that they are fully implemented.

2. Absence of strong institutional mechanisms

80. Governments need to take affirmative action in developing policies and institutions supportive of women's concerns. Partnership should be further promoted among cross-cutting sectors of society, particularly women's groups, community-based organizations, the private sector and non-governmental organizations. Many Governments have recognized their limits and are encouraging non-governmental organizations, the private sector and community groups to increase their participation in population, gender and development programmes.

3. Low technical capacities

81. Less than half of the mothers in developing countries deliver their babies under the supervision of a skilled birth attendant or health professional, a key factor in ensuring survival of both babies and mothers. Countries with the lowest rates of professionally attended births also share some of the world's highest rates of maternal mortality.

82. Capacity-building programmes need to be designed for both female and male workers. They need to focus not only on women's issues but also on the wider topic of gender concerns and human rights. Medical and nursing curricula should be carefully shaped so that gender issues are properly defined in the future planning and delivery of health services.

83. The attitude of many doctors and nurses often presents particular obstacles to women seeking to make informed decisions concerning their own health. It is essential for all health workers to respect the dignity and human rights of all clients, including the formal right to full information about their condition and the available treatment options. This requires a strategy for educating health workers at all levels to understand the significance and impact of applying a gender perspective in their own work.

4. Insufficient resource mobilization and allocation

84. While a number of developed countries have mobilized resources and contributed significantly to the flow of international assistance for population and development programmes, there are constraints that inhibit countries from mobilizing additional resources required for the full implementation of the Programme of Action of the International Conference on Population and Development. Among the constraints encountered by donor countries are: (a) declining official development assistance (ODA); (b) weakening economies and budget cuts; (c) lack of interest in supporting international population projects on the part of many foundations and philanthropists; (d) lack of understanding of the interdependence of population and development and of the importance of integrating population into development planning; and (e) the perception that there is no need to mobilize resources for population activities because population concerns are adequately addressed by the health and/or social sector.

85. At the same time, however, donor countries recognize the need to intensify efforts to mobilize resources for the continued implementation of the Programme of Action of the International Conference on Population and Development, and suggest the need to (a) explore new modalities, such as increased involvement of the private sector, including private foundations, in financing reproductive health services, including family planning; (b) increase donor support for inputs essential to the core International Conference on Population and Development activities, such as commodities, specialized training and data collection for monitoring and evaluation, where countries are not in a position to provide these inputs themselves; (c) increase international population and reproductive health assistance in the context of health sector reform and decentralization; and (d) encourage developing countries to increase domestic allocation for national population programmes and, in particular, to promote social sector programmes within the 20/20 initiative discussed at the International Conference on Population and Development and endorsed by the 1995 World Summit for Social Development held in Copenhagen.

V. Conclusions

A. Strengthening the incorporation of a gender perspective into policies, programmes and activities

86. Over the last five years, many countries have successfully implemented various elements of the Programme of Action of the International Conference on Population and Development to promote the advancement of women. Important lessons have been learned and good practices have been documented. Gender equality is increasingly being used as a fundamental guiding principle in population and development programmes, notwithstanding different social, cultural, economic and political contexts. Nonetheless, there is need to reinforce action in a number of areas, as identified during the special session of the General Assembly (June-July 1999) for the overall review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development (International Conference on Population and Development plus five).

87. Some of the actions needed to incorporate a gender perspective into policy, programmes and activities are described below:

1. The rights-based approach to population and development policies and programmes needs to be further developed and strengthened and human rights education should be incorporated into both formal and informal education processes.

2. Action should be taken to eliminate existing negative traditional, religious and cultural attitudes and practices that subjugate women and reinforce gender inequalities.

3. A gender perspective should be strengthened in policy formulation and programme implementation processes and in the delivery of services.

4. Mitigating measures should be adopted against the gender-differentiated impact of globalization of the economy and of the privatization of social and health sectors, especially on the poor.

5. All data and information systems should ensure availability of sex-disaggregated data for translating policy into strategies that address gender concerns and developing relevant gender impact indicators for monitoring progress.

6. The reproductive health needs of the aged should be addressed through the development of special programmes, services and institutional mechanisms that serve both men and women equally. The needs of other groups, such as the handicapped, immigrant communities, refugees and displaced persons, should also be addressed.

7. Every action should be taken both by Governments and by the private sector to remove all gender gaps and inequalities pertaining to women's participation in the labour market. Policies or legislation for equal pay for work of equal value must be instituted and enforced.

B. Recommended actions on gender, population and development

88. Actions recommended at the special session of the General Assembly (International Conference on Population and Development plus five) to promote gender equality include those described below:

1. The institutional capacity and technical expertise of staff in Government, and civil society, especially non-governmental organizations, should be strengthened in order to promote gender mainstreaming.

2. Education of children in gender awareness should be promoted as a crucial step in eliminating discrimination against women. Enrolment in school for girls must be enforced to ensure empowerment of women in future generations.

3. The participation of women at political and at all policy- and decision-making levels, including those for financial reforms and conflict prevention and resolution, should be accelerated.

4. The family is a powerful force in shaping women's lives. Strategies must be developed to promote gender equality at family level. It is also important to focus on the family as a unit of analysis for monitoring progress.

5. All countries should ratify the Convention on the Elimination of All Forms of Discrimination against Women, as well as the Optional Protocol thereto, and remove reservations where they exist. Legal frameworks need to be established to protect the human rights of women.

6. The media, parliamentarians and other similar entities should adopt and strengthen strategies to tackle negative attitudes about women and assist in enhancing the value that society places on women.

7. Zero-tolerance for all forms of violence against women and children, including rape, incest, sexual violence and sex trafficking, should be promoted.

8. The girl child should be protected, particularly from harmful practices, and her access to health, education and life opportunities should be promoted. The role of the family in safeguarding the well-being of girls should be enhanced and supported.

9. Action should be taken to promote a positive self-image and self-esteem among girls and women through information, education and communication strategies. Curricula reform should be undertaken to ensure that gender stereotypes are removed from all educational and training materials, and to promote male responsibility and partnership with women instead.

10. Men's own needs for reproductive and sexual health should be addressed, and they should be supported in taking responsibility for their own sexual behaviour.

11. All leaders at the highest levels of policy- and decision-making should speak out in support of gender equality, the empowerment of women and the protection of the girl child.

Notes

[1] *Report of the 1998 UNFPA Field Survey: Progress in the Implementation of the ICPD Programme of Action* (UNFPA, New York, January 1999).

[2] See *Report of the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, Nairobi 15-26 July 1985* (United Nations publication, Sales No. E.85.IV.10), chap. I, sect. A.

[3] See *Report of the United Nations Conference on Environment and Development, Rio de Janeiro, 3-14 June 1992*, vol. I, *Resolutions Adopted by the Conference* (United Nations publication, Sales No. E.93.I.8 and corrigendum), resolution 1, annexes I and II.

[4] See A/CONF.157/24 (Part I), chap. III.

[5] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

[6] See *Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995* (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annexes I and II.

[7] *Official Records of the General Assembly, Fifty-fourth Session, Supplement No. 38* (A/54/38/Rev.1), part one, chap. I, sect. A.

[8] General Assembly resolution 34/180, annex.

[9] See *Official Records of the Economic and Social Council, 1999, Supplement No. 7* (E/1999/27), chap. I, sect. A.

[10] See *1999 World Survey on the Role of Women in Development: Globalization, Gender and Work* (United Nations publication, Sales No. E.99.IV.8).

[11] *Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995* (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annex II.

[12] *Women's Health: Towards a Better World*, Report of the First Meeting of the Global Commission on Women's Health (Geneva, WHO, 1994).

[13] UNAIDS, "AIDS epidemic update", December 1999.

[14] R. Petchesky and K. Judd, eds., *Negotiating Reproductive Rights: Women's Perspectives across Countries and Cultures* (London, Zed Books, 1998).

[15] UNAIDS, press release, 23 November 1999.

[16] United Nations Children's Fund, *UNICEF Annual Report 1999* (New York, UNICEF, 1999).

[17] International Union for the Scientific Study of Population (IUSSP), Committee on Gender and Population, *Men, Family Formation and Reproduction* (Liège, Belgium, IUSSP, May 1998).

[18] United Nations Population Fund, *The State of World Population, 1997: The Right to Choose: Reproductive Rights and Reproductive Health* (New York, UNFPA, 1997).

[19] Ibid., chap. 3.

[20] See Deborah Meacham, "Go girls! young women claim their health rights and needs", *Women's Health Journal*, July 1998, pp. 29-36.

[21] United Nations Development Fund for Women (UNIFEM), *A Commitment to the World's Women: Perspectives on Development for Beijing and Beyond* (UNIFEM, 1995).

[22] *Risks, Rights and Reforms: A 50-Country Survey Assessing Government Actions Five Years after the International Conference on Population and Development* (New York, Women's Environment and Development Organization (WEDO), March 1999).

[23] Ibid.